CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1940

KP 23907

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

Authorization No. 345

REQUEST FOR RETENTION PERIOD

Department: Health

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. if available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. [ ] Establish retention period for records which are accumulating daily.

B. [ ] Dispose of present accumulation, no additional accumulation anticipated.

C. [ ] Microfilm and destroy originals.

D. [X] Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed.	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES [ ] NO [X]

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval — Robert E. Farber, M.D. — Title: Commissioner of Health — 3/28/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A. To be sold as scrap or waste paper	B. To be Burned or shredded	C. Historical, (to be transferred to Dept. of Legislative Reference.)
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	[ ]	[X]	[ ]

REMARKS:

C. P. Force — Records Management Officer — 3/28/63 Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

KP 23907

FILED ON FILM

IN

NUMERICAL ORDER

G59201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G59201 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1802 Thomas Ave
(c) Hospital or institution: 15-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1802 Thomas Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Virginia Aro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife James A Aro

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 21. 1880

8. AGE: Years 67 | Months 10 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John J Crompton

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Mariah Costello

15. Birthplace Ireland

16 (a) Informant James A Aro

(b) Address 1802 Thomas Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/48 (month) (day) (year)

(c) Cemetery or crematory Loraine Park

Location Baltimore Md

18 (a) Funeral director Wilson & Dye

(b) Address 1317 Eutaw St

19 (a) JAN 20 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19 1948, at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1948 to Jan 19 1948 and that I last saw h-- alive on Jan 17 1948

Immediate cause of death	Duration
Apoplexy	
Due to Nephritis	
Due to Hypertension	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W O Teasdale

Address 314 N Mt St Date signed 1/19/48 M. D.

VS 150

C59202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. C59202

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Norway, Sweden
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Sweden

3 (a) FULL NAME SVERRE WILBERG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Un Known Wildberg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 30 1912

8. AGE: Years	Months	Days	If less than one day
35	9	19	hr. min.

9. Birthplace TJOEBIK NORWAY (Town, county, and state)
10. Usual Occupation 2nd Engineer
11. Industry or business S. S. Fernbank

FATHER
12. Name (Unknown) Wildberg
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Norwegian Consulate
(b) Address Stewart Building

17 (a) Cremation (~~Burial~~, cremation, ~~or removal~~) (b) Date thereof 1/21/48 (month) (day) (year)
(c) ~~Cemetery or~~ crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) JAN 20 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 19, 1948, at 12.20 M a

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull
Contusion of brain
~~Due~~ Intracranial hemorrhage
Fractured left ribs.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-18-48 at 11.10 p. M. 24/2
(b) Where did injury occur? Bethlehem Ship Bldg. 1101 Key Balto. Md. Highway
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell from ladder.

23. Signature George A. Merrill M.D. Medical Examiner.
Date signed 1-19-48

VS 151

X

G59203

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 164c

G59203
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2044 Harford Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leon D. Wagner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married, widowed, or~~ divorced.
~~Male~~	~~White~~	Divorced

6 (b) Name of ~~husband or~~ wife Ellen Wagner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 6th 1890

8. AGE: Years	Months	Days	If less than one day
57	2	12	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name (Unknown) Wagner
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Leon D. Wagner Jr.
(b) Address 5405 Knell Ave.

17 (a) Burial (b) Date thereof 1/22/48
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ U. S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 JAN 20 1948 (Date rec'd by Registrar) (Huntington Williams, M.D.)

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Jan. 1948 at 12:12 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gunshot wound of head.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 14 Jan. 1948 at 11 A. M.
(b) Where did injury occur? 2044 Harford Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Jr. Forest Rangers, Inc. Camp While at work?
(d) Means of injury 22 Cal. rifle

23. Signature Wm. H. Kammer Jr. M.D.
Medical Examiner.
Date signed 19 Jan. 1948

VS 151

G59204 Birth Certificate # 98079 ✓

BALTIMORE CITY HEALTH DEPARTMENT ✓ 161a

CERTIFICATE OF DEATH

G59204 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 16-7
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 802 N. Carey St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Milton Scott Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Negro	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1947

8. AGE: Years	Months	Days	If less than one day
			26 hr. — min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Milton Scott
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Chestina White
15. Birthplace King & Queen Co. Va.

16 (a) Informant Chestina Scott
(b) Address 802 N. Carey St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Location Johns Hopkins Medical School JAN 19 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) JAN 20 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4 1947, at 7 P.M. 36

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3 1947 to Nov. 4 1947 and that I last saw him alive on Nov. 4 1947

Immediate cause of death Duration

Atelectasis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 1100 Druid Hill Ave Date signed 11/10/47

VS 150

N Lorenz Young X

G59205

LW 115452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30D

G59205 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 912 Barnabas Ct. (If rural give location)
(e) Citizen of foreign country? St. Lucia (Yes or No) If yes, name country

3 (a) **FULL NAME** Frank Emanuel, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17- 1891

8. AGE: Years	Months	Days	If less than one day
56	2	21	hr. min.

9. Birthplace S.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Emanuel Sr.
13. Birthplace S.C.

MOTHER
14. Maiden Name Nancy Davis
15. Birthplace S.C.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School JAN 19 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 20 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7- 1948, at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-24- 1947 to 1-7- 1948, and that I last saw him alive on 1-7- 1948

Immediate cause of death	Duration
Aortic Aneurysm, Ruptured	yrs.
Due to Lues	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. E. Robinson Jr. M. D.
Address Balt City Hosp Date signed 1/16/48

V S 150

G59206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G59206

48-00811

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 LIGHT ST.
(c) Hospital or institution: SOUTH BALTO. GEN. HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 39 hours 53 min.
(e) Length of stay in Baltimore (yrs., mos., or days) Same

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore 20 (If outside city or town limits, write RURAL and give town)
(d) Street No. 24 Selfridge Rd, Villa Gardens (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BABY GIRL BUSH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	W.	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 13, 1948

8. AGE: Years	Months	Days	If less than one day
		1	15 hr. 53 min.

9. Birthplace BALTO. S.B.G.H. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Herbert Bush
13. Birthplace UnKnown

MOTHER
14. Maiden Name Janet Heillius
15. Birthplace Ohio

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location Johns Hopkins Medical School JAN 19 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 20 1948 (Date rec'd by registrar) (Signature) for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 14 1948, at 6 05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 13 1948, to JAN 14 1948 and that I last saw HER alive on JAN 14 1948.

Immediate cause of death RESPIRATORY FAILURE — Duration

Due to ATELECTASIS

Due to PREMATURITY

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William B. Cogan Jr. M.D.
Address S.B.G.H. Date signed 1/16/48

VS 150

G59207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

123

G59207 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St 154
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2307 No Pulaski St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Garfinkle, Ida

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1878

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Meyer Potts
13. Birthplace Russia

MOTHER
14. Maiden Name Esther
15 Birthplace Russia

16 (a) Informant Samuel Garfunkel
(b) Address 2307 No Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) JAN 20 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19 1948, at 11:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1948 to Jan 19 1948, and that I last saw her alive on Jan 19 1948.

Immediate cause of death Intracranial hemorrhage, cause and site undetermined — Duration 2 wks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Marvin W. Davis M. D.

Address Sinai Hosp Date signed 1-19-48

VS 150

X

G59208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117B

G59208 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Monument St
(c) Hospital or institution: Levi 152
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 2017 Treasbury St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FRANK R. SHAPIRO

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-4766

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Hattie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Myer
13. Birthplace Russia

MOTHER
14. Maiden Name Leva
15. Birthplace Russia

16 (a) Informant Hattie Shapiro
(b) Address 2017 Treasbury St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 2160 Eutaw Place

19 (a) JAN 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/19 1948, at 3:50 p.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/16 1948, to 1/19 1948, and that I last saw h[illegible] alive on 1/19 1948.

Immediate cause of death: Hemorrhage from GI tract — Duration

Due to Bleeding ulcers Duodenal (2)

Due to

Other Conditions Pulmonary Edema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bleeding duodenal ulcers + Pulm Edema

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 1/19/48

VS 150

X

G59209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G59209

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted]
(c) Hospital or institution: University Hospital 9-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3031 Frisby St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDGAR Thomas LINDER

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-03-6014

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Elizabeth Kreiner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/12/1888

8. AGE: Years	Months	Days	If less than one day
59	5	5	hr. min.

9. Birthplace Baltimore County
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edgar Linder
13. Birthplace England

MOTHER
14. Maiden Name Mary Jane Reitenow
15. Birthplace Pa.

16 (a) Informant Mrs. Elizabeth Linder
(b) Address 3031 Frisby St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/21/1948 (month) (day) (year)
(c) Cemetery or [redacted] Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-3-5 E. Madison St.

19 (a) JAN 20 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 17, 1948, at 8.05 a M

21. I certify that I took charge of the remains described above, held an insp.& inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner.

Date signed 1-17-48

VS 181

C59210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. C59210

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 607 N. Potomac St.
(c) Hospital or institution: 7-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 607 N. Potomac St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME (Jean) JOHN B. RETZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Catherine J. Schulte
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/2/1874

8. AGE: Years	Months	Days	If less than one day
73	7	16	hr. min.

9. Birthplace Annapolis, Md.
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name John Retz
13. Birthplace France

MOTHER
14. Maiden Name Rosalee Bena
15. Birthplace France

16 (a) Informant Rosalee Jones - daughter
(b) Address 607 N. Potomac St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/21/1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 JAN 20 1948 (Date rec'd by registrar) (b) Hunting for Williams MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18, 1948, at 2.04 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1946 to Jan 18 1948 and that I last saw h alive on Jan 17 1948

Immediate cause of death	Duration
Bilateral Pneumonia	7 days
Fractured	
Due to General Cerebral Sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. W. Madison M. D.
Address 2 W. Read St Date signed 3/20/48

VS 150

C59211 11-6008 -AB

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

Registered No. C59211

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 3-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29days
(e) Length of stay in Baltimore (yrs., mos., or days) 21yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 20 S. High St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose Shalcosky Known as Balonowsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Jacob (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Gisinsky
13. Birthplace Poland

MOTHER
14. Maiden Name Rosie?
15. Birthplace Poland

16 (a) Informant Marion Shalcosky
(b) Address 1467 Reynold St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 22-48 (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location A. A. Co.

18 (a) Funeral director Wm. S. Fiallowski
(b) Address 2007 Eastern ave

19 JAN 20 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION AM

20. DATE OF DEATH Jan. 18- 1948 at 6.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-19- 1947 to 1-18 1948, and that I last saw her alive on 1-18- 1948

	Duration
Immediate cause of death Respiratory failure	5 hrs
Due to Pulmonary Infarction	5 hrs
Due to Pulmonic Stenosis	
due to cord bladder	
Due to post op. adhesive	
Other Conditions construction of space at L3	

(Include pregnancy within 3 months of death)

Date of operation 1948

Major findings of operation: Rupt. disc

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. M. D. Crosby

Address Balto City Hosp Date signed 1/19/48

VS 150

G59212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59212

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1812 Warwick Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 YRS
(e) Length of stay in Baltimore (yrs., mos., or days) 45 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore, MD
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 Warwick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME TIMOTHY BERNARD LEONARD

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife CATHERINE J. LEONARD
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUN. 9, 1865

8. AGE: Years	Months	Days	If less than one day
82	7	9	hr. min.

9. Birthplace PENNA.
(Town, county, and state)
10. Usual Occupation STONE MASON (RETIRED)
11. Industry or business

FATHER
12. Name JAMES LEONARD
13. Birthplace IRELAND

MOTHER
14. Maiden Name UNKNOWN
15 Birthplace "

16 (a) Informant Mr. Leonard Toner, nephew
(b) Address 705 Mt. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/21/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ NEW CATHEDRAL
Location BALTIMORE, MD.

18 (a) Funeral director WM. J. TURNER & SONS INC.
(b) Address NORTH & PA. AVES, BALTO., MD.

19 (a) JAN 20 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 18 1948, at 12 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944 to Jan. 18 1948 and that I last saw h alive on Jan. 18 1948

Immediate cause of death Hypostasis
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. B. Deadrick M. D.
Address 711 W. Mt. Royal Date signed 1/19/48

VS 150

C59213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered C59213

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 623 N. Calvert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 623 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME IDA MARY UDICH

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife William L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 28, 1873

8. AGE: Years	Months	Days	If less than one day
74	9	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business --

FATHER
12. Name Unknown-- Burch
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. Wm. L. Udich
(b) Address 623 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/20/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Loudon Park
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Ave; Balto., Md.

19 JAN 20 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Jan. 17, 1948 19.., at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 to Jan 17 1948 and that I last saw her alive on Jan 16 1948.

Immediate cause of death	Duration
(a) Myocardial insufficiency	6 Days
Due to (b) Arterio sclerosis	10 Yrs
Due to (c) Chronic myocarditis	6 Yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edw. S. Kennedy M. D.
Address 2858 Harford Date signed 1/19/48

VS 153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59214

G59214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2233 Division (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Dorman (Doman)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894.

8. AGE: Years 54 | Months | Days | If less than one day hr. min.

9. Birthplace Green Spring Valley (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant George Dorman Jr.
(b) Address 2233 Division Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 21 48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Wm Brooks
(b) Address 1463 N. Carey St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/17 1948 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/16 1948 to 1/17 1948 and that I last saw h[illegible] alive on 1/17 1948

Immediate cause of death Lobar Pneumonia (Rt.) — Duration

Due to

Due to

Other Conditions Uremia
Lung Abscess (Left)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Lobar Pneumonia. Lung Abscess

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Preston Grant M.D.
Address 1514 Division Date signed 1/18/48
for Wm H. Rammo, Jr.

VS 150

To be approved by Medical Examiner. Thomas J. Mullen M.D.

G59215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G59215 Registered No. 8 3a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. If correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1011 Bennett Place
(c) Hospital or institution: 18-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 Bennett Place (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES SPAIN

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife: Rosa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 5/16/1903

8. AGE: Years	Months	Days	If less than one day
44	7	26	hr. min.

9. Birthplace Greensville, N.C. (Town, county, and state)
10. Usual Occupation Leather Tanner
11. Industry or business Leather Factory

FATHER
12. Name David Spain
13. Birthplace N.C.

MOTHER
14. Maiden Name Laura Robinson
15. Birthplace N.C.

16 (a) Informant Rosa Spain (Wife)
(b) Address 1011 Bennett Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/ 2/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk.
Location Balto. County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (a) JAN 20 1948 (Date rec'd by registrar) (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 1948, at 9:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2/48 to 1/15/48 and that I last saw h alive on 1/15/48

Immediate cause of death	Duration
Cerebral Hemorrhage	4hrs/48
Due to with	
Due to Hypertension	1/3/48
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature X H Culleone M. D.
Address 1131 Hadda Date signed 1/19/48

X

G59216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G59216 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Redwood & Green Sts.
(b) Street address University Hospital
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Manchester
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Anthony Barber~~ Anthony Barber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret Barber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1892

8. AGE: Years	Months	Days	If less than one day
55	2	20	hr. min.

9. Birthplace Hungary
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Valentine Barber
13. Birthplace Hungary

MOTHER
14. Maiden Name Unknown
15. Birthplace Hungary

16 (a) Informant Mrs. Margaret Barber
(b) Address Manchester, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 20/48. (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge Cemetery
Location Dorsey, Md.

18 (a) Funeral director Harry H. Nikkle
(b) Address 4101 Edmondson Ave.

19 (a) JAN 20 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17 1948, at 8 35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1948, to Jan 17 1948 and that I last saw him alive on Jan 17 1948.

Immediate cause of death Coronary Thrombosis

Due to Arteriosclerosis

Due to

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: No

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. H. Powell Jr.
Address 2 mi Reisterstown Date signed 1/18/48 M. D.

J. H. Powell, Jr.

G59217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G59217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1606 Miller St.
(c) Hospital or institution: T-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1606 Miller St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Samuel Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Jannie Lee

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr) Dec. 22, 1879

8. AGE: Years 68 | Months - | Days 25 | If less than one day hr. min.

9. Birthplace Harford Co, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Lee
13. Birthplace Harford Co, Md

MOTHER
14. Maiden Name Susie ??
15. Birthplace Harford Co, Md

16 (d) Informant Viola Wallace
(b) Address 1606 Miller st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 19 1948 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Baltimore, Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Lane

19 (a) JAN 20 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

1/16/48 **MEDICAL CERTIFICATION** 2:30 A.M

20. DATE OF DEATH Jan 16 1948, at 2:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1948 to Jan 16 1948, and that I last saw him alive on Jan 15 1948.

Immediate cause of death Chronic Myocarditis — Duration unknown

Due to Probably 2 yrs

Due to

Other Conditions Interstitial Nephritis Hemiplegia (Left) generalized arterio-sclerosis (Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph J. Young M. D.

Address 1724 E. Monument St. Date signed 1/19/48

VS 150

937

G59218

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G59218 Registered No. 937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stony Run Drive
(c) Hospital or institution: 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3003 Guilford Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BERNARD C. MAGEE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years	Months	Days	If less than one day
82			hr. min.

9. Birthplace Baltimore Co. (Town, county, and state)

10. Usual Occupation Railroad Worker(Gen'l)

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Matilda Hughes
15. Birthplace Ireland

16 (a) Informant Mrs. Frank Doyle
(b) Address 3003 Guilford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/48 (month) (day) (year)
(c) Cemetery or crematory St. Josephs Cem
Location Texas, Md.

18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT AVE & 22ND

19 (a) JAN 20 1948 (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/19/48 19 , at 8:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 19 48 to Jan 19 19 48, and that I last saw him alive on Jan 16 19 48.

Immediate cause of death	Duration
Cardiac Decompensation	3 mo
Due to Arteriosclerotic Cardiovascular	10 yrs
Due to Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Edwin Mueller M. D.
Address 24 Reed St Date signed Jan 20 1948

V S 150

G59219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G59219

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland & Monument
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Kent
(c) City or town Rock Hall
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Max Alexander

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Augusta P. L. Alexander
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1/11/1883

8. AGE: Years	Months	Days	If less than one day
65		8	hr. min.

9. Birthplace Rock Hall, Md.
(Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER
12. Name Abraham Alexander
13. Birthplace Germany.

MOTHER
14. Maiden name Annie Lark,
15. Birthplace Germany.

16 (a) Informant Mrs. Augusta P. L. Alexander
(b) Address 1708 Eldamont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Sonnheim & Son
(b) Address 1902 Eutaw Place

JAN 20 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/19 1948 at 5:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 1948 to 1/19 1948, and last saw him alive on 1/19 1948.

Immediate cause of death	Duration
Cardiac insufficiency	1 wk
Due to Art. Sc. Hypertension	10 yrs
Due to	
Other Conditions Lymphosarcoma	8 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Max Rothbarth M.D.
Address Sinai Hosp Date signed 1/19/48

935

G59220

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓166

Registered No. G59220

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 7.4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 N. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA BELLE SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	colored	Deprocced

6 (b) Name of husband or wife Henry D. Ingram
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1925

8. AGE: Years	Months	Days	If less than one day
23	0	2	hr. min.

9. Birthplace Lilesville, N.C.
(Town, county and state)
10. Usual Occupation Maid
11. Industry or business Madison Hotel

FATHER
12. Name ? ?
13. Birthplace

MOTHER
14. Maiden Name Melie Ingram
15. Birthplace N.C.

16 (a) Informant Alossie May Smith
(b) Address 2009 Y St - Phila., Pa.

17 (a) Burial (b) Date thereof 1/23/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Wadesboro, N.C.

18 (a) Funeral director Chas. P. Law
(b) Address 502 Madison Ave

19 (a) JAN 20 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18, 1948, at 2.30 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of heart.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ✓ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-18-48 at about 2. a. M.
(b) Where did injury occur? 1407 Barnes St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature Carl H. Ryan M.D.
Medical Examiner
Date signed 1-19-48

G59221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

Registered No. G59221

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 6-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city limits, give county. If in BALTIMORE COUNTY, write RURAL and give town)
(d) Street No. 228 N. Montford Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LILLIE MAY HALL GRINELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Clarence Grinell

6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) 9/2/1924

8. AGE: Years 23 | Months 4 | Days 17 | If less than one day: hr. min.

9. Birthplace Monessen, Pa. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Alexander Hall
13. Birthplace N. C.

MOTHER
14. Maiden Name Callie Hall
15. Birthplace N. C.

16 (a) Informant mrs. Gertrude McRae
(b) Address 1233 N. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-22-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill, Md.

18 (a) Funeral director William Reese, II
(b) Address 108 Washington St. Annapolis, Md.

19 (a) JAN 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 19, 1948, at 12.20 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Stab-wounds of chest, with hemorrhage into chest and abdominal cavities.
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-19-48 at about 12 a. M.
(b) Where did injury occur? 222 N. Montford Ave. Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? Home
(d) Means of injury Sharp instrument

23. Signature George E. Merrill M.D.
Date signed 1-19-48 Medical Examiner.

VS 151

X

G59222 Dr. Alessi

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

G59222 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3029 Hamilton Avenue
(c) Hospital or institution: 27.4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3029 Hamilton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel M. Di Domenico

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	marred

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 13, 1905

8. AGE: Years	Months	Days	If less than one day
42	3	7	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name August Di Domenico
13. Birthplace Italy

MOTHER
14. Maiden Name Rose Mary Layacono
15. Birthplace Italy

16 (a) Informant Mrs. Margaret Di Domenico
(b) Address 3029 Hamilton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) JAN 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20 1948, at 6.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/30 1940 to 1/20 1948, and that I last saw h[illegible] alive on 1/20 1948.

Immediate cause of death	Duration
Coronary Thrombosis	15 min.
Coronary Thrombosis	2½ yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Di Domenico M. D.
Address 6217 Harford Rd Date signed 1/20/48

V S 150

X

G59223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G59223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2742 Huntington Ave 12-7

(c) Hospital or institution: None

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in Baltimore (yrs., mos., or days) 54 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2742 Huntingdon Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME JACOB ELMER CARTER

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 215-18-7684

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Minerva Carter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 October 1885

8. AGE: Years	Months	Days	If less than one day
X 62 63	3	6	hr. min.

9. Birthplace X Granville Co., North Carolina (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business X Self

FATHER

12. Name Joseph John Carter

13. Birthplace X Granville Co North Carolina

MOTHER

14. Maiden Name Alverda ~~Alberta~~ E. Hopkins

15. Birthplace Baltimore County, Maryland

16 (a) Informant Mrs. Kittie Carter

(b) Address 6402 Liberty Rd. Baltimore, 7 Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 21, 1948 (month) (day) (year)

(c) Cemetery or crematory St. Thomas Cemetery

Location Garrison Forest, Md.

18 (a) Funeral director Miller & Layton

(b) Address 4510 Liberty Heights Ave.

19 (a) JAN 20 1948 Rec'd by registrar (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18 1948, at 9 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 1948, to Jan 18 1948 and that I last saw him alive on Jan 18 1948.

Immediate cause of death Heart Failure — Duration 30 hours

Due to Bronchial Asthma — 60 years

Due to

Other Conditions Uraemia, Pneumonia — 6 days, 6 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None performed

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Millard J. Traynor Jr. M. D.

Address 3400 Woodbine Ave. Balt 7, Md. Date signed Jan 19 1948

VS 150

G59224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G59224

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 307 N. Fremont Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES FRANKLIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace West River, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name George Wooden
13. Birthplace Md.

MOTHER
14. Maiden Name Harriet ?
15. Birthplace Md.

16 (a) Informant Mrs. Mary Simms
(b) Address 952 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-21-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) JAN 20 1948 (Local Registrar) (b) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15, 1947, at 9 P. M

21. I certify that I took charge of the remains described above, held an insp& inq. Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C. V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Ryze M.D. Medical Examiner

Date signed 1-16-48

G59225

B.C: 48-01153

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

160a

G59225
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County Balto City
(c) City or town Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 North Point Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No) —
If yes, name country —

3 (a) FULL NAME BABY GIRL PIGGINS

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day
			3 hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name William A. Piggins
13. Birthplace Huntington, Penna.

MOTHER
14. Maiden Name Beatrice E. Lutch
15. Birthplace Randallstown, md.

16 (a) Informant Wm. A. Piggins
(b) Address 521 North Point Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 20 1948 (month) (day) (year)

(c) Cemetery Mount Olive
Location Randallstown, md

18 (a) Funeral director Wm Berryman & Son
(b) Address Reisterstown, md.

19 (a) JAN 20 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/19 1948 at 7:55 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 1/14 1948 to 1/19 1948, and that I last saw her alive on 1/19 1948.

Immediate cause of death	Duration
Subarachnoid Hemorrhage	
Due to	
Due to	
Other Conditions Congenital Heart	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Susman M. D.
Address Sinai Hospital Date signed 1/20/48

G59226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G59226

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6721 Youngstown Ave. 26-b
(c) Hospital or institution: Sacred Heart of Mary Church
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 59 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.,
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 Dundalk Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bronislaw Rajowski (Rakowski)

3 (b) If veteran, name war ———

3 (c) Social Security Account No. ———

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Josephine Sophia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1887

8. AGE: Years	Months	Days	If less than one day
60 61	8	6	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Ignatius Rakowski
13. Birthplace Poland

MOTHER
14. Maiden Name Valeria Sliwinska
15. Birthplace Poland

16 (a) Informant Mrs. Jennie Stachowik, Daughter
(b) Address 308 S. Chapel Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-23-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location Baltimore County

18 (a) Funeral director John H. Weber
(b) Address 401 S. Chester Street

19 (a) JAN 20 1948 (Date rec'd by Registrar) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Jan. 1948, at 12:10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammerer Jr. M.D.
Medical Examiner.
Date signed 18 Jan. 1948

G59227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G59227

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address [redacted] Cold Spring Lane

(c) Hospital or institution: Cold Spring Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.

(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 635 Wyatt St (If rural give location)

(e) Citizen of foreign country: WYETH (Yes or No) If yes, name country

3 (a) FULL NAME William W. Barker

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Widowed

6 (b) Name of husband or wife Emma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 13th 1880

8. AGE: Years	Months	Days	If less than one day
67	10	5	hr. min.

9. Birthplace Washington D.C. (town, county, and state)

10. Usual Occupation Stock Clerk

11. Industry or business Montgomery Wards

FATHER 12. Name J. F. Barker

13. Birthplace Washington D.C.

MOTHER 14. Maiden Name Laura V. Cadwallader

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Margaret Moog

(b) Address Argyle Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/[illegible]/48 (month) (day) (year)

(c) Cemetery or crematory Mikvah Cem

Location Edgewood & Edmondson Ave

18 (a) Funeral director Peter J. Gawronski Son

(b) Address 9603 Pulaski St

19 (a) JAN 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13th 1948, at [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1st 1947 to Jan 13th 1948, and that I last saw him alive on Jan 16 1948.

Immediate cause of death	Duration
Coronary thrombosis	1 hour
Due to Generalized Arteriosclerosis	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Herman R. Kleiman M. D.

Address 3803 Edmondson Ave Date signed 1/19/48

VS 150

G59228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

G59228

Registered No.

MARGIN RESERVED FOR BINDING.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution: Sinai Hospital 2B-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 weeks
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3 N Woodington Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Creighton, George W.

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Marie L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 23rd 1894

8. AGE: Years 53 | Months 2 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Sergt Police Dept

11. Industry or business B&O R.R.

FATHER
12. Name George W. Creighton
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Cecelia R. Carr
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Marie L. Creighton
(b) Address 3 N. Woodington Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem
Location 4300 Old Frederick Rd.

18 (a) Funeral director John J Gowan & Son
(b) Address 901/03 Hollins St.

19 (a) JAN 20 1948 (Date received by Registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - 19 19 48, at 6 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-11 19 47 to 1-19 19 48, and that I last saw h[im] alive on 1 - 19 19 48.

Immediate cause of death hypertensive cardiovascular disease — Duration: Several yrs

Due to with uremia and heart failure — Duration: 3 mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Mann D. Dann M. D.
Address Sinai Hosp Date signed 1-19-48

VS 150

X

G59229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1108

G59229 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 765 Vine St.
(c) Hospital or institution: 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 765 Vine St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dolphus Lemon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 15, 1907

8. AGE: Years	Months	Days	If less than one day
40	11	19	hr. min.

9. Birthplace Maning, S.C. (Town, county, and state)

10. Usual Occupation Contractor

11. Industry or business

FATHER
12. Name Anthony Lemon
13. Birthplace Maning, S.C.

MOTHER
14. Maiden Name Painter Johnson
15. Birthplace Maning, S.C.

16 (a) Informant William Lemon
(b) Address 1515 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 21, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 3229 W. Schroeder St

19 (a) Jan 20 1948 (Date received by registrar) (b) Registrar's signature

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 19 48 at 11 1/2 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 19 48 to Jan 16 1948 and that I last saw h alive on 19

Immediate cause of death Coronary Thrombosis — Duration 6 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 1515 W Lexington St Date signed 1/20/48

C59230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C59230

OC-48-00976 / 159

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 601 North Broadway

(c) Hospital or institution: The Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)

(d) Street No. 207 Hamlin Court (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Baby Hall

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			6 hr. 51 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER — 12. Name James Hall

13. Birthplace Maryland

MOTHER — 14. Maiden Name Helene Cornish

15. Birthplace Maryland

16 (a) Informant Johns Hopkins Hospital Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 20 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St.

19 (a) JAN 20 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17, 1948, at 7:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 16, 1948, to Jan. 17, 1948, and that I last saw him alive on Jan. 17, 1948.

Immediate cause of death Atelectasis — Duration 6 hrs

right

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. Hunter Long M. D.

Address Date signed

VS 150

Johns Hopkins Hospital × 1-19-48

C59231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. C59231

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 712 W. Franklin St.
(c) Hospital or institution: 17-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 712 W Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Palmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert Palmer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16 1896

8. AGE: Years 51 | Months 3 | Days 29 | If less than one day: hr. min.

9. Birthplace Essex Co. Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Edmond Eggs
13. Birthplace Essex Co Va.

MOTHER
14. Maiden Name Lillie Pierson
15. Birthplace Va

16 (a) Informant Robert Palmer
(b) Address 712 W Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 21 1948
(months) (days) (years)
(c) Cemetery or crematory Fredrick Burial Co
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) JAN 20 1948 (b)
(Date rec'd by reg.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 1948 at 2.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1948 to Jan 15 1948 and that I last saw her alive on Jan 15 1948.

Immediate cause of death Pneumonia (left lobe) — Duration 1 week

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Garland Churchill Jr. M. D.
Address 902 W. Franklin St. Date signed 1-16-48

VS 150

X

G59232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54B

Registered No. G59232

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 221 S. North Pk Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William John Spare

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	married

6 (b) Name of husband or wife Anna Catherine (Baker)
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Feb 16 - 1891

8. AGE: Years	Months	Days	If less than one day
56	11	-	hr. min.

9. Birthplace Charles Town, Pa (Town, county, and state)
10. Usual Occupation Tavern Prop.
11. Industry or business Own

FATHER
12. Name Oscar Spare
13. Birthplace Pa

MOTHER
14. Maiden Name Catherine P.
15. Birthplace Pa

16 (a) Informant Mrs. Anna C. Spare
(b) Address 221 S. North Pk Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-19-48 (month) (day) (year)
(c) Cemetery or crematory Mechanicsville
Location Washington Co. Md.

18 (a) Funeral director John J. Connelly
(b) Address 48 Eastern Ave

19 (a) JAN 20 1948 (Date rec'd by registrar) (b) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16 1948, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 9 1948 to Jan 16 1948 and that I last saw h[illegible]ive on Jan 13 1948.

Immediate cause of death Cerebral hemorrhage

Due to Brain Tumor

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Jan 13, 1948

Major findings of operation: Brain tumor

of autopsy Hemorrhage, Brain tumor

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lloyd L. McCormick M. D.
Address N. P. G. H. Date signed 1-19-48

VS 150

C59233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. C59233

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division St

(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4hrs

(e) Length of stay in Baltimore (yrs., mos., or days) 23yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 821 N. Bond St (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country None

3 (a) FULL NAME Emma Hines

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Negro

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/2/1912

8. AGE: Years 35 | Months 7 mos | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Grimesland, N.C. (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER

12. Name Jerry Preson

13. Birthplace Middleburg N.C.

MOTHER

14. Maiden Name Maggie Edwards

15. Birthplace Grimesland N.C.

16 (a) Informant Charolette Jas Kins

(b) Address 821 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 25 '48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Brooklyn, Md.

18 (a) Funeral director Joseph L. Russ

(b) Address 1200 McCulloh St

19 JAN 20 1948 Huntington Williams, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/19 1948, at 7:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/19 1948, to 1/19 1948, and that I last saw her alive on 1/19 1948.

Immediate cause of death Subarachnoid Hemorrhage — Duration ?

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William Garner

Address 1514 Division St Date signed 1/19/48

VS 150

X

G59234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G59234

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2105 Hollins St.
(c) Hospital or institution: 20-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2105 Hollins St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jane (Mollie) Speaks

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Henry Clay Speaks
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) November 2, 1863

8. AGE: Years	Months	Days	If less than one day
84	2	17	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name William H. Colley
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Hesse
15. Birthplace Maryland

16 (a) Informant Mrs. Ursula Marshall
(b) Address 2105 Hollins Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-21-48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Maryland

18 (a) Funeral director George L. Lehnert
(b) Address 2101 Fredrick Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

JAN 20 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19, 1948, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1948 to 1/19 1948, and that I last saw h[illegible] alive on 1/18 1948

Immediate cause of death: Bronchopneumonia — Duration: 3 days
Due to:
Due to:
Other Conditions: Arteriosclerosis Hypertension
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. A. Capps M. D.
Address 2145 W Balto St Date signed 1-19-48

107

C59235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C59235

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.A.
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 10
(e) Length of stay in Baltimore (yrs., mos., or days) 26

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3372 E Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nicola Franze

3 (b) If veteran, name war

3 (c) Social Security Account No. 062-07-1929

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Franze

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1 1895

8. AGE: Years 52 | Months 5 | Days 17 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Stone Mason

11. Industry or business

FATHER
12. Name Constantine Franze
13. Birthplace Italy

MOTHER
14. Maiden Name Susie Lettese
15. Birthplace Italy

16 (a) Informant Pete Fudaze
(b) Address 251-S. Broadway St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 21 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road.

18 (a) Funeral director Wendell Doppel
(b) Address 312 S. Highland Ave

19 (a) JAN 20 1948 (Date rec'd by registrar) (Signature) Wm Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/18 1948, at 7:00 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Ralph Schmeisser M.D. Medical Examiner.
Date signed 1/18/48

VS 151

BG59236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 59236

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 320 S. Albemarle St
(c) Hospital or institution: 3-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 320 S. Albemarle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Johanna Conarell Conarell

3 (b) If veteran, name war: No.

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dominick

6 (c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Nov. 20 1885

8. AGE: Years: 62 Months: 1 Days: 27 If less than one day: hr. min.

9. Birthplace: Balto. (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER
12. Name: Vincent Scola
13. Birthplace: Italy

MOTHER
14. Maiden Name: Anna Barber
15. Birthplace: Italy

16 (a) Informant: Sadie De Angelis
(b) Address: 2617 Aisquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 21 48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: 4300 Belair Rd.

18 (a) Funeral director: The Dipaul Bro
(b) Address: 1800 E. Lombard St.

19 (a) JAN 20 1948 (b) Huntington Williamsport

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/19 1948, at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic C-V disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: C. L. Tillmanks M.D.
Medical Examiner.
Date signed 1/20/48

X

G59237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 P

G59237 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4801 Pennington Ave
(c) Hospital or institution: 25
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 4801 Pennington Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. yard 4801
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Kaisler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	Widowed

6 (b) Name of husband or wife Emanuel Kaisler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1876

8. AGE: Years	Months	Days	If less than one day
71	10	15	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation housework
11. Industry or business

FATHER
12. Name Joseph Lapicka
13. Birthplace Bohemia

MOTHER
14. Maiden Name Not known
15. Birthplace Bohemia

16 (a) Informant Mrs. Frank Bernath
(b) Address 4801 Pennington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 21 48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director Frank Leach & Son
(b) Address 900 N. Chester St.

19 (a) Jan 22 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18, 1948, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1948 to Jan 18 1948 and that I last saw h alive on Jan 18 1948

Immediate cause of death	Duration
coronary occlusion	
Due to hypertension	
Due to	
Other Conditions carcinoma stomach	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip W. Kaestner M.D.
Address 202 Calvert Av Date signed Jan 22

V S 150

94a

G59238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G59238

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 E. Biddle St.
(c) Hospital or institution: 8-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 E. Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Scherrer

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-03-3901

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Anna Marcoske

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) July 17, 1876

8. AGE: Years 71 | Months 6 | Days 1 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business Robinson Oil Co.

FATHER 12. Name Peter Scherrer

13. Birthplace Germany

MOTHER 14. Maiden Name Katherine Afland

15 Birthplace Germany

16 (a) Informant Mr. James Scherrer

(b) Address 404 Cambria St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/21/48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd

18 (a) Funeral director John F. Kenny Inc

(b) Address 716 Light St

19 (a) JAN 21 1948 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18 1948, at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1938 to Jan. 18 1948, and that I last saw him alive on Jan. 17 1948.

Immediate cause of death	Duration
Cerebral Thrombosis	16 hours
Due to Cerebral Arteriosclerosis	
Due to General Arterio-sclerosis	
Other Conditions Myocardial Degeneration	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Vincent V. Dooka M.D.

Address 8451 Ford. Pk. Ave. Date signed 1/19/48 M. D.

83 C

G59239

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G59239 Registered No. 124a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital ~~or institution~~: Sinai 8.2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 N. Gay St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George R. Williams

3 (b) If veteran, name war

3 (c) Social Security Account No 213-10-6145

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar 28th 1862

8. AGE: Years	Months	Days	If less than one day
85	9	2/28	hr. min.

9. Birthplace East Boston, Mass. (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Md. Dry dock Co.

FATHER
12. Name Geo. Henry Williams
13. Birthplace Nova Scotia

MOTHER
14. Maiden Name Julia (Unknown)
15. Birthplace Boston, Mass.

16 (a) Informant Mrs. Laura C. Pyle
(b) Address 1607 N. Gay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Md
Location (Baltimore)

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St

19 JAN 21 1948 (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 January 1948, at 2.05 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1948 to Jan 19 1948, and that I last saw him alive on Jan 19 1948.

Duration

Immediate cause of death Toxemia due to Peri nephric abscess, left

Due to Pyonephrosis left with left lateral deviation & perforation

Due to of ~~pelvis~~ left kidney pelvis

Other Conditions Benign prostatic hypertrophy 2nd degree (Include pregnancy within 3 months of death)

Date of operation Jan 7, 1947

Major findings of operation: Peri nephric abscess - left

of autopsy: same + L. pyonephrosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Marvin Sharp M. D.
Address Sinai Hospital Date signed Jan 19 1948

X

G59240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. G59240

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 327 Illchester Avenue
(c) Hospital or institution: Home 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 327 Illchester Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mae Carroll Hewell

3 (b) If veteran, name war: no
3 (c) Social Security Account No. -

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John Hewell
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Fev. 20, 1894

8. AGE: Years 53 | Months 11 | Days - | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Alfred Carroll
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Ella Hennessy
15 Birthplace: Baltimore, Maryland

16 (a) Informant: John Hewell
(b) Address: 327 Illchester Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan. 23, 48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: Wm. Cook, Inc.
(b) Address: 1217 St. Paul Street

19 (a) JAN 27 1948 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20 1948, at 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 15 1948 to Jan 20 1948 and that I last saw her alive on Jan. 19 1948

Immediate cause of death: Chronic Nephritis — Duration: Not Known
Due to: Arteriosclerosis — Not Known
Due to: Cerebral Hemorrhage — 10 Mon.
Other Conditions: Arterial Hypertention —

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide at M
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify place)
(e) Means of injury

23. Signature: William R. Linton M. D.
Address 2824 St. Paul St. Date signed Jan 20, 1948

G59241

tn. 100709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G59241

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1731 McHenry St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 26/ 1880

8. AGE: Years 67 | Months 4 | Days 23 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Steven D. Church (D
13. Birthplace Ohio

MOTHER
14. Maiden Name Jane A. Brown (D
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director William Lee
(b) Address 1219 Light St

19 (a) JAN 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19th 1948, at 7.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 18 1946, to Jan. 19 1948 and that I last saw h er alive on Jan. 19 1948

Immediate cause of death: Bronchopneumonia

Due to: Hypertensive Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: On a home

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Hawkins M D
Address Balt City Hosp Date signed 27 Jan 48

X

G59242

G59242

BC-48-01287

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 1606

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 27-1
(b) Street address 100 N Broadway
(c) Hospital or institution: Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 410 Church Home Hospital (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Theiss

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) ~~October~~ 1-19-48

8. AGE: Years	Months	Days	If less than one day
			20 hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Carl Phillip Theiss
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mildred May Burns
15. Birthplace Baltimore, Md.

16 (a) Informant Carl Phillip Theiss
(b) Address 4103 Willow Avenue Baltimore Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/21/48 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill Cemetery
Location Annapolis Road

18 (a) Funeral director Emory N. Blight Jr.
(b) Address 4914 Belair Road

19 JAN 21 1948 (Date rec'd by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 20 1948 at 12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 19 1948 to 20 1948.
and that I last saw him alive on Jan 20 1948.

Immediate cause of death	Duration
Prematurity (12 wks premature)	
Due to	
Due to	
Other Conditions Transverse presentation	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lee M. Howard M. D.

Address Church Home Hosp. Date signed 1-20-48

VS 153

159

G59243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G59243

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St.
(c) Hospital or institution: Good Samaritan Home 2-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 das
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1900 Bl. Aliceanna St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Elizabeth Knowles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife William Knowles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 2, 1879

8. AGE: Years	Months	Days	If less than one day
68	6	18	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15 Birthplace

16 (a) Informant C. W. Lee
(b) Address Index, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 23 48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. Wolfe St.

19 (a) JAN 27 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20 19 48, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 19 48 to Jan 20 19 48 and that I last saw h alive on Jan 20 19 48

Immediate cause of death	Duration
Gastro Carcinoma	
Due to	
Due to	
Other Conditions Malignancy (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.
Address 27 N. Carey Date signed 1/20/48

VS 150

G59244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

G59244 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4339 Sheldon Ave.
(c) Hospital or institution: 26-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4339 Sheldon Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George F. Moersberger

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bessie Moersberger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 9, 1878

8. AGE: Years	Months	Days	If less than one day
69	9	11	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Paul Moersberger
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Ditzel
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Bessie Moersberger
(b) Address 4339 Sheldon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 23/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto. Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 JAN 21 1948 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20/48 19 , at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Jan 20 1948
and that I last saw him alive on Jan 19 1948.

Immediate cause of death	Duration
Coronary Thrombosis.	
Due to Hypertensive Cardio-Vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? while at work?
(Specify type of place)
(e) Means of injury
23. Signature L. B. Evans
Address 3402 Erdman Ave. Date signed 1/21/48

V S 150

G59245

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 469

G59245
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2200 Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith Strauss

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Walter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1-14

8. AGE: Years	Months	Days	If less than one day
34			hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Abraham Rosen
13. Birthplace Russia

MOTHER
14. Maiden Name Fannie
15. Birthplace Russia

16 (a) Informant Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-21-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd + Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 200 Eutaw Pl

19 (a) (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19 1948 at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 Dec 1947 to 19 Jan 1948. and that I last saw her alive on 19 Jan 1948.

Immediate cause of death	Duration
Carcinoma of the pancreas	6 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Manuel H. Davis M. D.
Address Sinai Hosp Date signed 1-19-48

VS 150

G59246

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

G59246
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave
(c) Hospital or institution: West Balto General 15.4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No 1906 No Pulaski St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida Sarubin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Mordecai

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 73

8. AGE: Years 75 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Bernard

13. Birthplace Russia

MOTHER 14. Maiden Name unknown

15. Birthplace Russia

16 (a) Informant Dr Benj Sarubin

(b) Address 2128 West North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-21-48 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Philg Rd Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 2600 Eutaw Place

19 (a) JAN 21 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20, 1948, at 5 AM PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/29 1947 to 1/20 1948, and that I last saw h alive on 1/20 1948.

Immediate cause of death ACUTE PULMONARY EDEMA — Duration

Due to ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to

Other Conditions DIABETES MELLITUS

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Albert Butensky M.D.

Address Balto General Hospital Date signed 1/21/48

VS 150

927

C59247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 463

C59247 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2039 Ruxton Ave
(c) Hospital or institution: 15-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2039 Ruxton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hyman Shapiro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Shoe maker

11. Industry or business

FATHER
12. Name Morris
13. Birthplace Russia

MOTHER
14. Maiden Name Annie
15. Birthplace Russia

16 (a) Informant Mrs Eva Steinberg
(b) Address 2039 Ruxton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/21/48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Bowley Lane

18 (a) Funeral director Jack Lewis Inc
(b) Address 2160 Eutaw Pl.

19 JAN 21 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - 20 - 1948 at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to Jan 1948 and that I last saw him alive on 19 Jan 1948

Immediate cause of death: Myocardial failure — Duration: 3 mo

Due to: Chronic Anemia — 1 yr

Due to: Carcinoma Glandular with metastases — 3 mo

Due to: Peptic Ulcer — 3 mo

Other Conditions: Bronchial asthma — 20 yrs. 20 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H H Baylus M.D.
Address 1600 Wilkens Ave Date signed 20 Jan 48

G59248 H-2-44.

BALTIMORE CITY HEALTH DEPARTMENT ✓ X G59248
Registered No. 40207

CERTIFICATE OF DEATH 157E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Frederick
(c) City or town Frederick
(If outside city or town limits, write RURAL and give town)
(d) Street No. 203 W. 5th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James D. Frederick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-1-48

8. AGE: Years	Months	Days	If less than one day
		20	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name James Frederick
13. Birthplace Md

MOTHER
14. Maiden Name Mary Frederick
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-22-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Lutheran Cem.
Location Middletown, Md.

18 (a) Funeral director M. R. Etchison & Son
(b) Address Frederick, Md.

JAN 21 1948 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-20 1948, at 3:19 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19 1948 to 1-20 1948, and that I last saw him alive on 1-20 1948.

	Duration
Immediate cause of death Cardiac failure	2 days
Due to ? Myocarditis, acute	2 days
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Crigler, Jr. M. D.
Address The Johns Hopkins Hospital signed 1-20-48

VS 150

G59249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G59249 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Grea st
(c) Hospital or institution: University Hospital 27-9
(d) Length of stay in hospital or inst (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 90 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4648 Marble Hall Rd (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Jennie Berry

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced WIDOW
6 (b) Name of husband or wife Charles H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1865

8. AGE: Years 82 Months 9 Days 19 If less than one day hr. min.

9. Birthplace Pittsburgh, Pa. (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name James C. Baines
13. Birthplace Pittsburgh, Pa.

MOTHER
14. Maiden Name Rachael Brown
15. Birthplace Pittsburgh, Pa.

16 (a) Informant Mrs. Aldine J. Bird.
(b) Address 4648 Marble Hall Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/48 (month) (day) (year)
(c) Cemetery or crematory Washington Cem.
Location Washington, Pa.

18 (a) Funeral director Wash. J. Tickner & Sons Inc
(b) Address 4th & Pa. Ave., Balto., Md.

19 (a) (Date received by Registrar) (b) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-20 1948, at 6:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-17 1948 to 1-20 1948, and that I last saw her alive on 1-20 1948.

Immediate cause of death Cardiac failure — Duration

Due to Chronic myocarditis

Due to arteriosclerosis

Other Conditions Related pleural effusion, ascites (Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard E. Hall M. D.
Address Wash. Hosp. Date signed 1-20-48

G59250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G59250 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 106 S. High Street
(c) Hospital or institution: 3-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 S. High Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Salvatore Farace

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife Francesca
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Italy (Town, county and state)
10. Usual Occupation Fruit Dealer
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Francesca Farace
(b) Address 106 S. High St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 22-1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Holy Redeemer Cem.
Location 4430 Belair Road

18 (a) Funeral director Joseph Farace Inc
(b) Address 201 S Gleanmount Ave

19 (a) Jan 22 1948 (Date received by registrar) (b) Registrar's signature Wilhelmina Miller

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1948, at 3 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 8 1948, to 1-20 1948; and that I last saw her alive on 1-20 1948;

Immediate cause of death Coronary Occlusion

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
10 Days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Theodore Rosenfeld M. D.
Address 5707 Belair Rd Date signed 1-21 1948

G59251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

G59251

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 32nd + Calvert Sts
(c) Hospital or institution: Union Memorial Hospital 12-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Northwood Apts
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Kathryn Weaver (KATHRYN ADAMS WEAVER)

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Wm Carl Weaver

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Sept 18, 1896

8. AGE: Years 51 | Months 4 | Days 2 | If less than one day hr. min.

9. Birthplace Oklahoma (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Adams
13. Birthplace Missouri

MOTHER
14. Maiden Name Nora McSweeney
15. Birthplace Iowa

16 (a) Informant Hospital records
(b) Address Mr. Wm. Weaver-husband.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-21-48 (month) (day) (year)

(c) Cemetery or crematory
Location Stillwater-Okla.

18 (a) Funeral director Stewart Mortuary
(b) Address 108 W. Northwood

JAN 21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1948, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1948 to Jan 20 1948, and that I last saw h[illegible] alive on Jan 20 1948.

Immediate cause of death Chronic glomerulonephritis — Duration 6 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George P. Thomas M. D.
Address Union Memorial Hospital Date signed 1-20-48

VS 150

G59252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1634

Registered No. G59252

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 25-5
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1032 Stoll Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Millie A. Haaland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: OLE HAALAND

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1 - 1915

8. AGE: Years 32 | Months 6 | Days 19 | If less than one day hr. min.

9. Birthplace: Balto Md (Town, county, and state)

10. Usual Occupation: at home

11. Industry or business

FATHER
12. Name: Jacob Haralsen
13. Birthplace

MOTHER
14. Maiden Name: Helma
15. Birthplace

16 (a) Informant: Mrs. Ole Haaland
(b) Address: 2619 Guilford Ave

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 1-20-48 (month) (day) (year)
(c) Cemetery or crematory: Greenmount
Location: Baltimore

18 (a) Funeral director: Leonard J. Keck
(b) Address: 5305 Harford Rd.

21 1948 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION 30

20. DATE OF DEATH January 20, 1948 at 12 P. M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Asphyxiation due to carbon monoxide

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/20/48 at ? A. M.
(b) Where did injury occur? 1032 Stoll Place
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury: Inhalation of gas fumes

23. Signature Harry J. Walker M.D. Medical Examiner.
Date signed 1/20/48

G59253

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G59253 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~7605 Riddle ave~~
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County Baltimore
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7605 Riddle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John R. Leffert

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Laura Leffert
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr) March 1-

8. AGE: Years	Months	Days	If less than one day
37	10	17	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Maintenance Man
11. Industry or business Sparrows Pt School

FATHER
12. Name John C Leffert
13. Birthplace Md

MOTHER
14. Maiden Name Lillie D. Ward
15 Birthplace Balto

16 (a) Informant Laura J Leffert
(b) Address 7605 Riddle ave

17 (a) Burial (b) Date thereof Jan 22
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location Catonsville

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Pleasant St

19 (a) JAN 23 1948 (b) Huntington Williamsville, Md
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18 1948 at 7 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 18 1948 to Jan 18 1948 and that I last saw him alive on Jan 18 1948

Immediate cause of death Cardiac failure
Due to Coronary Thrombosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
3

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bernard L. Cohen M.D.
Address Sinai Hosp, Balto Md Date signed 18 Jan 48

G59254

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G59254 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3909 Ridgecroft Road
(c) Hospital or institution: West Balto Hosp 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3909 Ridgecroft (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Adolphson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec 27

8. AGE: Years	Months	Days	If less than one day
28	-	25	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Book Keeper
11. Industry or business

FATHER
12. Name Carl Adolphson
13. Birthplace Sweden

MOTHER
14. Maiden Name Elizabeth Siebert
15. Birthplace Balto

16 (a) Informant Mrs Louisa Linz
(b) Address 2519 Orleans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 27th (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2018 Orleans St

19 (a) (Date received by registrar) (b) Huntington Williams, Registrar

JAN 27 1948 VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 21, 1948 at 1 35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 8 1948 to Jan 21 1948 and that I last saw him alive on Jan 20 1948

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Subarachnoid Hemorrhage	
Due to Essential hypertension malignant type	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard Lucker M. D.
Address West Balt Gen Hosp Signed Jan 24, 48

G59255 Entry 45660 1946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30F

Registered G59255

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 Mc Culloh St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annette Foreman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1946

8. AGE: Years 1 | Months 5 mo | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Dalton De Bose
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary Foreman
15. Birthplace South Carolina

16 (a) Informant Dept. Public Welfare
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location Johns Hopkins Medical School JAN 19 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 21 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1947 to Sept 9 1947 and that I last saw h.. alive on Sept 9 1947.

Immediate cause of death	Duration
Congenital Syphilis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Preston Grant M. D.

Address 1214 Division Date signed 1/19/48

VS 150

G59256

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

Registered No. G59256

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave.
(c) Hospital or institution: Maryland General 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 D.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 Lemmon St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Luis Cisternes

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Eunice Cisternes
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 18. 1894

8. AGE: Years 53 | Months 8 | Days 1 | If less than one day: hr. min.

9. Birthplace: Chile (Town, county, and state)
10. Usual Occupation: Machinest
11. Industry or business: Bethelehem Steel Co.

FATHER
12. Name: Joseph Cisternes
13. Birthplace: Chile

MOTHER
14. Maiden Name: Mary Ferinna
15. Birthplace: Chile

16 (a) Informant: Hospital Records.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-23-48 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Balto. County, Md.

18 (a) Funeral director: George L. Schwab
(b) Address 2481 Frederick Ave.

19 (a) JAN 22 1948 (Date rec'd by registrar) (b) [illegible] Wilkinson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 JAN. 1948, at 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 16 JAN. 1948 to 19 JAN. 1948 and that I last saw him alive on 18 JAN. 1948.

Immediate cause of death	Duration
Acute Cardiac Dilatation	1 Hr.
Due to Bronchopneumonia	30 Days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lloyd E. Taylor M.D. M. D.
Address 3902 Greenmount Ave. Date signed 20 Jan '48

VS 150

G59257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1639

G59257 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore & Hanover Sts.
(c) ~~Hospital or institution~~: Lord Baltimore Hotel
(d) Length of stay in ~~hospital or inst.~~ (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) ~~State~~ Md. (b) County Baltimore
(c) City or town Monkton (If outside city or town limits, write RURAL and give town)
(d) Street No. 1600 Union Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carl E. Weiss

3 (b) If veteran, name war

3 (c) Social Security Account No. 247-01-9358

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Lucia Rose Weiss
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 21st 1903

8. AGE: Years	Months	Days	If less than one day
44	2	29	hr. min.

9. Birthplace N. Y. (Town, county, and state)
10. Usual Occupation Executive
11. Industry or business Hand Printers Inc.

FATHER
12. Name Carl E. Weiss
13. Birthplace Switzerland

MOTHER
14. Maiden Name Bertha Ehrenburg
15. Birthplace Switzerland

16 (a) Informant Lucia R. Weiss
(b) Address Monkton Md.

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 1/24/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) JAN 22 1948 (Date rec'd by registrar) (b) ~~Huntington~~ Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20, 1948, at 4 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cyanide Poisoning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/20/48 ? M.
(b) Where did injury occur? Lord Baltimore Hotel
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Ingestion of cyanide

23. Signature Carl V. Snyder M.D. Medical Examiner
Date signed 1/21/48

VS 151

C59258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. C59258

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH'S HOSP 9-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3m. 4d
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County ~~BALTIMORE~~
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 516 E. 23rd ST
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CHARVAT, Mary Agnes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband William Charvat
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/10/98

8. AGE: Years	Months	Days	If less than one day
49	3	10 days	hr. min.

9. Birthplace BALTIMORE (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business Own Home

FATHER
12. Name Thomas Connolly
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth (Unknown)
15. Birthplace Ireland

16 (a) Informant Elizabeth M. Kelly
(b) Address 518 E. 23rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.

19 JAN 22 1948 (Date rec'd by Registrar) Huntington Williams, Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/20 1948, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/17 1947, to 1/20 1948, and that I last saw her alive on 1/20 1948.

Immediate cause of death CARD: RESPIRATORY FAILURE — Duration

Due to GENERALIZED CARCINOMATOSIS

Due to CARCINOMA UTERUS & OVARIES

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry A Porter M.D.
Address St Joseph's Hosp Date signed 1/20/48

G59259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G59259

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1114 Guilford Avenue
(c) Hospital or institution: Home 11-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 Guilford Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Benford C. Stonnell

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 216 09 0418

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Leola D.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Geb. 4, 1881

8. AGE: Years 66 | Months 11 | Days 17 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Jane
15 Birthplace Virginia

16 (a) Informant Wm. B. Stonnell
(b) Address 6009 Burgess Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 23, 48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Baltimore

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) JAN 22 1948 (Date rec'd by reg'r) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21-48 19 , at 3:30A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1948 to Jan. 21 1948, and that I last saw h alive on Jan 20th 1948.

Immediate cause of death: Coronary Thrombosis — Duration 24 hours
Myocardial dropping — 2 Yrs.
Due to Arterio-Sclerosis
Due to 0
Other Conditions 0

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. Stallard M. D.
Address 300 N. Calvert St Date signed

Date 2 Ind. X

G59260

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

42a

Registered No. G59260

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 104 Enfield Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 yrs 12 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 104 Enfield Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Gerbig

3 (b) If veteran, name war: -
3 (c) Social Security Account No.: -

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: -
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 22, 1884

8. AGE: Years 63 | Months 4 | Days 29 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Buyer

11. Industry or business Hochschild Kohn Co.

FATHER
12. Name George Gerbig
13. Birthplace Md

MOTHER
14. Maiden Name Katie J. Gerbig
15 Birthplace Md

16 (a) Informant Mr. Robert H. Gerbig
(b) Address 104 Enfield Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Frederick Ave

18 (a) Funeral director John J. Denny Inc
(b) Address 741 Light St Baltimore, Md

19 (a) JAN 22 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20 1948, at 9:30 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14 1948 to Jan 20 1948, and that I last saw her alive on Jan 20 1948.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur About home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A Evans M. D.

Address 612 N 40 St Date signed

VS 159

G59261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G59261

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1709 Edison Highway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 - 3
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 Edison Highway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHESTER F. Miskelly

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-3402

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widower

6 (b) Name of husband or wife Katharine M. Miskelly
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1883

8. AGE: Years	Months	Days	If less than one day
64	2	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Foreman
11. Industry or business Gas & Electric Co.

FATHER
12. Name Joseph V. Miskelly
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Emma F. Chester
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Edward F. Miskelly
(b) Address 3119 Dudley Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 1/24/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Lasach Funeral Home
(b) Address 7401 Belair Rd.

19 (a) JAN 22 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION P

20. DATE OF DEATH January 20 19 48 at 10:40 M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl Ryan M.D.
Medical Examiner.
Date signed 1-21-48

G59262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G59262

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 242 N. Exeter St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-2

(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 242 S. Exeter St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Giovannucci or Nuch

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife: late Assunta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8 1862

8. AGE: Years	Months	Days	If less than one day
85	3	12	hr. min.

9. Birthplace Parga Lucca (Italy)
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Ranierd Giovannucci
13. Birthplace Italy

MOTHER
14. Maiden Name Assunta ?
15. Birthplace Italy

16 (a) Informant Annita Dell 'Uomo Daughter
(b) Address 242 S. Exeter St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Jan. 22 1948 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Vace
(b) Address 52 N. Morley St.

19 (a) JAN 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/19 1948 at 10 25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/14 1947 to 1/19 1948 and that I last saw h[illegible] alive on 1/19 1948

Immediate cause of death: Chronic Myocarditis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dwight Faultney M. D.

Address 441 N. Edmondson Ave Date signed 1/21/48

VS 150

G59263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59263

X 119a ✓

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address RUTLAND & MONUMENT STS

(c) Hospital or institution: SINAI HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:

(a) State NY (b) County SUFFOLK

(c) City or town NEW YORK
(If outside city or town limits, write RURAL and give town)

(d) Street No. .....
(If rural give location)

(e) Citizen of foreign country? .....(Yes or No)
If yes, name country .....

3 (a) FULL NAME JANE ALICE CONWELL ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) 12 2 47

8. AGE: Years	Months	Days	If less than one day
	1½	19	..... hr. ..... min.

9. Birthplace COUNTY SUFFOLK, N.Y.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Unknown
13. Birthplace ?

MOTHER
14. Maiden Name Unknown
15. Birthplace ?

16 (a) Informant Hospital records
(b) Address

17 (a) BURIAL (b) Date thereof 1 22 48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Bnai Israel Corp.
Location SOUTHERN AVENUE

18 (a) Funeral director Sol LEVINSON & BROS
(b) Address 1124-26 W. NORTH AVE.

19 (a) JAN 22 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/17 1948 at 10:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1948 to 1/17 1948, and that I last saw h. alive on 1/17 1948.

Immediate cause of death	Unknown	
Due to	Diarrhea Malnutrition	
Due to	& Cyanosis	
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? .....
(Specify type of place) While at work? .....

(e) Means of injury .....

23. Signature Harold Lucoma M. D.

Address Sinai Hospital Date signed 1/24/48

VS 150

X

G59264 BC-48-0148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161c

Registered No. G59264

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp. 14+
(d) Length of stay in hospital or inst. (~~year, mos.~~, or days) 2 days
(e) Length of stay in Baltimore (~~year, mos.~~, or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 Eutaw Place
(If rural, give location)
(e) Citizen of foreign country? No (~~Yes~~ or No)
If yes, name country —

3 (a) FULL NAME George Harrison

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
M.	W.	

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15, 1948

8. AGE: Years	Months	Days	If less than one day
—	—	5	— hr. — min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business —

FATHER
12. Name Ralph Harrison
13. Birthplace Pa.

MOTHER
14. Maiden Name Jean Breathwaite
15. Birthplace Pa.

16 (a) Informant Mrs. Jean B. Harrison
(b) Address 1619 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Mt. Olivet
Location Balto, Md.

18 (a) Funeral director John O. McGuckin Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) JAN 22 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 Jan 1948, at 3:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-18 1948 to 1-18 1948, and that I last saw him alive on 1-19 1948.

Immediate cause of death Respiratory Failure — Duration 5 days

Due to Erythroblastosis Foetalis Severe

Due to —

Other Conditions Severe Jaundice

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. M. Baron Jr. M. D.
Address Univ. Hosp Date signed 1-19-48

C59265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. C59265

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3901 Chatham Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15"
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3901 Chatham Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irene Segall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years 37 | Months | Days | If less than one day hr. min.

9. Birthplace Boston Mass (Town, county, and state)

10. Usual Occupation Coat Pusmen

11. Industry or business

FATHER
12. Name Morris
13. Birthplace Russia

MOTHER
14. Maiden Name Tressa
15 Birthplace Russia

16 (a) Informant Father Segall
(b) Address 3901 Chatham Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-22-48 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 2116 Eutaw Place

19 (a) JAN 22 1948 (Must be filed by 3rd day) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-21- 1948 at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to date 19..., and that I last saw her alive on Jan 19 1948.

Immediate cause of death Coronary thrombosis — Duration 4 hours

Due to Hypertension — 2 years
Arteriosclerosis — 4 years

Due to

Other Conditions Diabetes mellitus — 19 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alan Bernstein M. D.
Address 1109 N Calvert Date signed 1/24/48

V S 150

94a

G59266

SACKS

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

Registered No. G59266

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3003 Granada Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3003 Granada Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie Sacks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Abraham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Samuel
13. Birthplace Russia

MOTHER
14. Maiden Name Baila
15. Birthplace Russia

16 (a) Informant Abraham Sacks
(b) Address 3003 Granada Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-22-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Levy Inc
(b) Address 2100 Eastern Ave

19 JAN 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-20 1948, at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945, to Jan 20 1948, and that I last saw h[illegible] alive on Jan 20 1948

Immediate cause of death	Duration
Broncho-pneumonia	2 days
Due to Cerebral Arteriosclerosis	4 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Manuel Levy M. D.
Address 4818 Reisterstown Rd Date signed Jan. 22 1948

X

T659267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. 659267

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N J (b) County Pennsylvania
(c) City or town 103 Wilkinsburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. 103 Wright ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Craig T. Shaffer

3 (b) If veteran, name war | 3 (c) Social Security Account No. —

4 Sex Male | 5 Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-23-47

8. AGE: Years | Months 10 | Days 24 | If less than one day — hr. — min.

9. Birthplace N J
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Craig Shaffer
13. Birthplace

MOTHER 14. Maiden Name Doris Carpenter
15. Birthplace N J

16 (a) Informant Records
(b) Address

17 (a) Burial (b) Date thereof Jan. 23 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Eglinton Cemetery
Location Cherrybrow, N. J.

18 (a) Funeral director Walter Rumple Readley
(b) Address 1922 W. North Ave

19 JAN 22 1948 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-21-48, at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15-48 to 1-21-48
and that I last saw h[illegible] alive on 1-21-1948.

	Duration
Immediate cause of death Circulatory failure	Unknown
Due to Congenital Heart Disease Transposition of great Vessels	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 1-21-48
Major findings of operation: Transposition of Great Vessels
Date of autopsy 1-21-48

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F. Crigler, Jr. M.D.
Address The Johns Hopkins Hosp. signed 1-22-48

VS 150

FURTADO

C59268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

Registered No. C59268

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1042- S. Sharp St. 913 Lemmon Hall St.
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Antonia M. Furtado (Toney Mendes)

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed,~~ or ~~divorced~~.
Male	Colored	Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 18, 1889

8. AGE: Years	Months	Days	If less than one day
58	6	-	..... hr. ..... min.

9. Birthplace Catarille Island, Port.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Christian Mendes
13. Birthplace Catarille Island, Port.

MOTHER
14. Maiden Name Catherine Mendes
15. Birthplace Catarille Island, Port.

16 (a) Informant Gerald Mendes
(b) Address 4W Dill St. Providence Rd. Md.

17 (a) Burial (b) Date thereof 1-23-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem
Location A. A. Co., Md.

18 (a) Funeral director Isaac L Brunston
(b) Address 108 W. Montgomery St

19 (a) JAN 22 1948 Registrar for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Jan. 1948, at 4:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to Probable syphilitic heart disease

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Wm. H. Kammer M.D.
Medical Examiner.
Date signed 19 Jan. 1948

VS 151

X

059269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

Registered No. 059269

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1408 Battery Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 Battery Av.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian M. Kelly
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: George H. Kelly
6 (c) If alive, give age; if dead, how long a widow/er: years

7. Birth date of deceased (mo., day, yr.) June 1-1876

8. AGE: Years 70 | Months 7 | Days 19 | If less than one day: hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Theodore McNeir
13. Birthplace Washington, D.C.

MOTHER
14. Maiden Name Annie Shue
15. Birthplace Michigan

16 (a) Informant Mrs. Thelma Zepler
(b) Address 1408 Battery Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Jan 24 49 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Edmondson Ave.

18 (a) Funeral director John R. Kenny
(b) Address Baltimore Md

19 JAN 22 1949 (Date rec'd by registrar) Livingston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-20- 1948, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1947 to Jan. 20 1948.
and that I last saw her alive on 1-19 1948.

Immediate cause of death — Duration

Due to Carcinoma of Liver — 4 mo.

Due to Valvular disease of heart. — years

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 11-18-47.
Major findings of operation: Mass in liver
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jno. Rich. C. Blake M. D.
Address Med. Arts Bldg Date signed

VS 150

X

G59270 (1) G59270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 945 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary May

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1848

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Chester Md (Town, county, and State)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name ?
13. Birthplace Chester Md

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Blanch Byron
(b) Address 602 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 21-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director Joseph Kasiuckas
(b) Address 602 Washington Blvd

19 (a) JAN 22 1948 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18, 1948, at 12 45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 1-19-48

VS 151

G59271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G59271

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Tudor arms Apt.
(b) Street address — University & 40
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write Rural, and give town)
(d) Street No. University & 40 St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah Davis Holley

3 (b) If veteran, name war — None
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Chas J. Holley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1859

8. AGE: Years	Months	Days	If less than one day
88	6	11	hr. min.

9. Birthplace Columbia Pa (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Augustus Young
13. Birthplace Not known

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Harold Holley Son
(b) Address Tudor Arms Apt 1

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-24-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Stewart Mortuary Co.
(b) Address 108 W Monument

19 (a) JAN 22 1948 (Date rec'd by registrar) Waiting for Williams MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1948 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1948 to Jan 21 1948 and that I last saw h alive on Jan 20 1948.

Immediate cause of death	Duration
Myocarditis	2 mos
Due to	
Due to Age	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A Evans M. D.
Address 602 N 40 St Date signed

VS 3

G59272

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 83a

G59272 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Homewood Ave. #18
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2117 Homewood Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Virginia Deckert

3 (b) If veteran, name war - none
3 (c) Social Security Account No. none

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Henry F. Deckert
6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) Oct. 31-1872

8. AGE: Years 75 | Months 3 | Days 19 | If less than one day 20 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Samuel Bennet
13. Birthplace New York State

MOTHER
14. Maiden Name Virginia Owings
15 Birthplace Baltimore, Md.

16 (a) Informant Mrs. Perl S. Streiman (daughter)
(b) Address 2117 Homewood Ave. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-22-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore City

18 (a) Funeral director Stewart & Mowen Co.
(b) Address 108 West North Ave.

19 (a) JAN 22 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1948 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1945 to Jan 20 1948 and that I last saw her alive on Jan 20 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	10 hrs
Due to Generalized Arteriosclerosis	Indefinite
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury

23. Signature Nathaniel M Beck M. D.
Address 100 E. 23rd St Date signed Jan 21-48

VS 150

G59273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered G59273

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto General Hospital 2 E 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 44 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4405 Springdale Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Ida Snellenberg~~ Ida B. Snellenberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Samuel L. Snellenberg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 29, 1871

8. AGE: Years	Months	Days	If less than one day
76	2	21	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Mr. Waltemeyer
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Malinda ?
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Fred J. Willey
(b) Address 4405 Springdale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 23, 1948 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Willis Lamotte
(b) Address 4510 Liberty Heights Ave.

19 (a) JAN 22 1948 (Date rec'd by registrar) (b) Burlington, Millinocket, Me. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 Jan 1948, at 2:48 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5 Dec 1947 to 20 Jan 1948 and that I last saw her alive on 19 Jan 1948.

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	
Mesenteric Thrombosis	2 days
Due to Fracture, hip, with left hemiplegia	5 Dec '47
Due to	
Other Conditions Fecal Fistula	

(Include pregnancy within 3 months of death)
Date of operation: Nov 27 '47, 20 Dec '47
Major findings of operation: Fracture, neck femur, left; Gangrene, sacral
of autopsy: Fistula

PHYSICIAN 47
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 5 Dec 47 at M
(c) Where did injury occur? Balto, Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? (Specify type of place)
(e) Means of injury Fall down stairs

23. Signature for Wm H. Kammer Jr. by Howard J. Moreau, M.D.
Address WBGH Date signed 21 Jan 48 M. D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

659274

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

Registered No. 659274

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3725 Hudson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3725 Hudson St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Irene L. Fiesler
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Johanna Fiesler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2-1856

8. AGE: Years	Months	Days	If less than one day
91	11	18	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Fiesler
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Pechultz
15. Birthplace Germany

16 (a) Informant Joseph Fiesler
(b) Address 3725 Hudson St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1-23-48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave

18 (a) Funeral director John C. Miller Inc
(b) Address 2437 E. Oliver St.

19 (a) JAN 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-20-1948 at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1st 1947, to Jan 20 1948 and that I last saw him alive on 1/19 1948.

Immediate cause of death	Duration
(a) Cerebral Hemorrhage	
Due to (b) Arteriosclerosis	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Huntington Williams M.D.
Address 3323 E Baltimore Date signed 1/22/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

359275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 1243

Registered No. 359275

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 12-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) Yoa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 East Federal Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Myrtle T Cornish

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/18/1903

8. AGE: Years 44 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name William Cornish
13. Birthplace Cambridge, Md

MOTHER
14. Maiden Name Jane Collins
15. Birthplace Md.

16 (a) Informant Leonard Cornish
(b) Address 504 East St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Edmondson Ave.

19 (a) JAN 22 1948 (Date rec'd by registrar) (Signature for Williams M

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19, 1948, at 8 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Atelectasis of lungs.
Fatty degeneration of liver
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 1-19-48

VS 181

G59276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G59276 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Genl Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 5
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 St. Paul St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROBERT B. Jones

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife MAY N. JONES (nee Neuman) 6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1862

8. AGE: Years	Months	Days	If less than one day
85	4	26	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Salesman of Stocks

11. Industry or business

FATHER
12. Name - Jones
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Godman
15. Birthplace Md.

16 (a) Informant Mrs. May N. Jones
(b) Address 1616 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) JAN 22 1948 (Date rec'd by registrar) (Municipality for Williams, Md.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 21, 1948 at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 7 1948 to Jan. 21 1948 and that I last saw him alive on Jan. 20, 1948.

Immediate cause of death Debility — Duration

Due to Paget's Disease

Due to

Other Conditions Path. fract. of neck of R. Femur
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 1215
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 1-7-48 at 10:20 A.M.
(c) Where did injury occur? Chas. + Lanvale Sts. Balto (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public (Specify type of place) While at work? No
(e) Means of injury Slipped + fell

23. Signature Mary N. Brady M. D.
Address Md. Gen. Hosp. Date signed 1-21-48
For Dr. Wm. H. Knowles, by Howard J. Malloy, M.D.

VS 150 To be Approved by Chief Med. Examiner

G59277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

G59277
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bay Yard & Russell Sts
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28-4
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 427 Drury Lane (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John L. Dunnock.

3 (b) If veteran, name war —
3 (c) Social Security Account No. 212-01-2008

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife MYRTLE K.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB 28, 1878

8. AGE: Years 69 | Months 10 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Supt.
11. Industry or business Swindell Bros Co.

FATHER
12. Name Levin Dunnock
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Langrall
15. Birthplace Md.

16 (a) Informant Mrs. Myrtle K. Dunnock
(b) Address 427 Drury Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Md.

18 (a) Funeral director Wm J. Tickner & Sons
(b) Address North & Pa. Aves. Balto, Md.

19 (a) Jan. 22, '48 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21st 1948, at 10:40 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Jan death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature William J. Helfrich M.D.
Medical Examiner.
Date signed Jan 21, 1948

VS 191

G59278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

G59278 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3008 Poplar Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3002 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CATHERINE MARY CAMPBELL

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Robert L. Campbell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): Dec. 4, 1901

8. AGE: Years: 46 | Months: 1 | Days: 16 | If less than one day: hr. min.

9. Birthplace: St. John's, Newfoundland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: John Foley
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Mary Kelly
15. Birthplace: Newfoundland

16 (a) Informant: Mr. Robert L. Campbell
(b) Address: 3002 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/48 (month) (day) (year)
(c) Cemetery or crematory: Western Cem. Balto., Md.
Location:

18 (a) Funeral director: WM. J. TICKNER & SONS Balto., Md.
(b) Address:

19 (a) JAN 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20, 1948, at 7:30a M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1943 to Jan. 1948, and that I last saw h[illegible] alive on Jan 16 1948.

	Duration
Immediate cause of death: Cerebral hemorrhage	1 day.
Due to: Hypertensive cardiovascular disease	5 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Donn Monroe M. D.
Address 3108 Belair Rd Date signed 1-21-48

VS 150

G59279

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G59279 Registered No. 121B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1518 NORTHWICK RD.
(c) Hospital or institution: — 27-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 NORTHWICK RD. (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country —

3 (a) FULL NAME LIDA C. M. DRESSEL

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NO

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOWED

6 (b) Name of husband or wife GEORGE F. DRESSEL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 27, 1877

8. AGE: Years	Months	Days	If less than one day
70	10	23	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name H. R. KOLLER
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MARGARET R. CURRY
15. Birthplace MARYLAND.

16 (a) Informant MRS. MARGARET HOUSE (DAUGHTER)
(b) Address 1518 NORTHWICK RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1/23/48 (month) (day) (year)
(c) Cemetery or crematory GREENMOUNT
Location BALTIMORE, MD.

18 (a) Funeral director WM. J. TICKNER & SONS.
(b) Address NORTH & PA. AVES., BALTO., MD.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 20 1948 at 11 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 1948 to Jan 20 1948 and that I last saw h alive on Jan 20 1948

Immediate cause of death	Duration
Cardiac Insufficiency	
Due to Chronic Bronchitis	
Due to Chr. Nephritis	
Other Conditions Chr. Gall Bladder Dis.	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur C. Manninger M. D.
Address 800 E North Ave Date signed 4/21/48

VS 150

G59280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. G59280

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 237 N. Schroeder St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARGIE ROCHE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1880

8. AGE: Years 67 | Months 5 | Days 21 | If less than one day hr. min.

9. Birthplace Crisfield, Maryland
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Argie Roache
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mary Roache
(b) Address 237 N. Schroeder St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 23 48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18, 1948, at 8.20 M.

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of sigmoid

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Edward L. Ryan M.D.
Medical Examiner.
Date signed 1-19-48

G59281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

G59281 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 849 W. Franklin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 841 W Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1908

8. AGE: Years	Months	Days	If less than one day
39	4		hr. min.

9. Birthplace Lanes S.C. (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER — 12. Name Robert Brown
13. Birthplace Lanes S.C.

MOTHER — 14. Maiden Name Susie George
15. Birthplace Lanes S.C.

16 (a) Informant Beckett Brown
(b) Address 2856 Booker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 24, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 323 N Schroeder St

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1948 at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14 1948 to Jan 20 1948 and that I last saw h alive on 19

Immediate cause of death Cerebral hemorrhage — Duration 7 dy
Due to Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature
Address 709 E Lexington Date signed 1/22/48 M. D.

VS 150

X1

G59282 BALTIMORE CITY HEALTH DEPARTMENT

G59282

BC - F 62389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G59282 Registered No. 115c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BARIUM RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Provident Hospital

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 - 6 1 day.

(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1514 Piper Ct. (If rural give location)

(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Vera Christie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	Negro.	

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 18, 1942.

8. AGE: Years	Months	Days	If less than one day
5 yrs.	2	2	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Christie

13. Birthplace Rolandsville, Md.

MOTHER 14. Maiden Name Mary Anderson

15. Birthplace Danville, Virginia

16 (a) Informant Mrs. Mary Christie

(b) Address 1514 Piper Ct. Holabird Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 23 48 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.

Location

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N. Schroeder St.

19 (a) (b) Baltimore, Md. (Signature and title of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20/48 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/19/48 to 11/20/48 and that I last saw her alive on 11/20/48.

Immediate cause of death	Duration
(a) Pulmonary Edema P.O.	
Status Thymicus Lymphaticus	
Due to	
Due to	
Other Conditions P.O. Tonsillectomy	

(Include pregnancy within 3 months of death)

Date of operation 11/20/48.

Major findings of operation: Enlarged thymus gland, Chronic inflamed tonsils.

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury Dr. T. B. Hyg[illegible]

23. Signature Dr. W. H. Robinson M. D.

Address President Hosp. Date signed 11/21/48.

for W. H. Robinson, Jr. by Howard J. Morris, M.D. X

VS 150

G59283

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G59283
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hosp. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
6 City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 W. 33rd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Solonie E. Petty

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Effie M. Petty (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Sept 26, 1877

8. AGE: Years	Months	Days	If less than one day
70	3	24	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Guard.
11. Industry or business Same steel.

FATHER
12. Name Thomas Petty
13. Birthplace Maryland.

MOTHER
14. Maiden Name Catherine Pollison
15. Birthplace Maryland

16 (a) Informant Effie M. Petty
(b) Address 518 W 33rd St

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof Jan 22/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location

18 (a) Funeral director Chas. W. Robinson
(b) Address 3615-17 Chestnut Ave

19 (a) Jan 22 1948 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1948, at 3:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 11 1948, to Jan 20 1948, and that I last saw h IM alive on Jan 20 1947.

Immediate cause of death	Duration
acute Pulmonary Edema	
Due to Cardiac Failure	
Due to Arteriosclerotic Heart Disease & Coronary Thrombosis	
Other Conditions Massive G. I. Hemorrhage (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Hollingsworth M. D.
Address Univ. Hosp. Date signed 1-20-48

J. M. Hollingsworth

VS 150

G59284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G59284 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 710 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Brisbane (Brisbon)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	N	Married

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15 1893

8. AGE: Years	Months	Days	If less than one day
54	5	15	hr. min.

9. Birthplace Camden S. C. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Robert Brisbon
13. Birthplace S. C.

MOTHER
14. Maiden Name Amelia ?
15. Birthplace S. C.

16 (a) Informant Elizabeth Brisbon
(b) Address 718 N. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-24-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Williams & Jackson
(b) Address 916 Penna. Ave.

JAN 22 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/20 1948 at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/20 1948 to 1/20 1948 and that I last saw h[illegible] alive on 1/20 1948

Immediate cause of death C-V Accident

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Fulton Grant M. D.
Address 1514 Division Date signed 1/21/48

G59285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G59285 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 510 N FRANKLINTOWN RD.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 510 N. FRANKLINTOWN RD. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARIETTA ROTAN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	WHITE	WIDOWED

6 (b) Name of husband or wife GEORGE A. ROTAN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 12. 1869

8. AGE: Years	Months	Days	If less than one day
78	5	9	hr. min.

9. Birthplace MARTINSBURG. W. VA. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name CHARLES G. HENKEL
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARY MUELLER
15. Birthplace VIRGINIA

16 (a) Informant MARIETTA FULLER
(b) Address 2714 W. FRANKLIN ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1/24/48 (month) (day) (year)
(c) Cemetery or crematory MT. OLIVET
Location Frederick Line

18 (a) Funeral director Joseph L. Centrone, Jr.
(b) Address 414 N. Franklintown Rd.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1948, at 1130 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Jan 21 1948 and that I last saw her alive on Jan 21 1948.

Immediate cause of death	Duration
Respiratory failure	
Due to Arteriosclerotic Cardiovascular renal disease	
Due to	
Other Conditions Hemiplegia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. Shorofsky M.D.
Address 601 N. Monroe Date signed 1/24/48 M. D.

VS. 150

JAN 22 1948

G59286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

G59286

Reg. No. 116429

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 714 Port St. (South
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Casper Goetz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~June~~ July 15/1890

8. AGE: Years 57 | Months 6 | Days 6 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Shipworker

11. Industry or business

FATHER

12. Name Henry Goetz

13. Birthplace Germany

MOTHER

14. Maiden Name Mary Hass

15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-24-1948 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director Lilly & Zeiler Inc.

(b) Address 403 South Wolfe Street

19 (a) 22 1948 (b) [illegible] Williams

(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21/1948 19 ..., at 6.10 A.M. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 8/ 19 48 to Jan. 21 19 48, and that I last saw h[illegible] alive on Jan. 21/1948 19 ...

Immediate cause of death Carcinoma, anaplastic, primary site undet with metastases, multiple — Duration 6 mos.?

Due to Osteall, ribs — Coughs? 1 week

Due to Hemiplegia, left due to Bcerebral metastases

Other Conditions Hypertensive Cardio-vasc disease & Auricular fib. Rating — ?

(Include pregnancy within 3 months of death)

Date of operation 1-12-48

Major findings of operation: Biopsy - metastatic anaplastic Carcinoma

of autopsy: not done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.

Address Baltimore City Hosp. Date signed 1-21-48

G59287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G59287

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1807 Braddish Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 da
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 Braddish Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William B. Middlekauff

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-10-8757

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 19 1877

8. AGE: Years	Months	Days	If less than one day
70.	11	1	hr. min.

9. Birthplace Hagerstown, Md.
(Town, county and state)

10. Usual Occupation Baker

11. Industry or business Steamed Bakeries

MOTHER / FATHER

12. Name William D. Middlekauff

13. Birthplace Hagerstown, Md

14. Maiden Name Lilla A. Leonard

15. Birthplace Hagerstown Md

16 (a) Informant Mrs Barbara E. Middlekauff

(b) Address 2 Boyle Oak Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/48 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem

Location Woodlawn, Md

18 (a) Funeral director John J. Cowan & Son

(b) Address 901-03 E. Collins St.

19 (a) Date received 1948 (b) Registrar Huntington Williams, M.D.
(Date received by registrar)

JAN 22 1948

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20th 1948, at 8:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 28 1947, to Jan 20 1948, and that I last saw h. alive on Jan. 20 1948.

Immediate cause of death Carcinoma of liver — Duration 4 mos.

Due to —

Due to —

Other Conditions arteriosclerosis — 2 yrs.

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. McDermott

Address 1136 Poplar Grove St. Date signed 1/21/48 M. D.

G59288

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G59288

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3119 Oakford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3119 Oakford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William A Healy

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Agnes E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12th 1869

8. AGE: Years	Months	Days	If less than one day
68	4	10	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation
11. Industry or business Retired

FATHER 12. Name Patrick Healy
FATHER 13. Birthplace Ireland

MOTHER 14. Maiden Name Bridget Burke
MOTHER 15. Birthplace Ireland

16 (a) Informant Mr Martin Healy
(b) Address 3119 Oakford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/48 (month) (day) (year)
(c) Cemetery or crematory Mt Bethel
Location 4200 Old Frederick Rd

18 (a) Funeral director John J Gavan & Son
(b) Address 901-03 Hollins St

19 (a) JAN 22 1948 (Date rec'd by registrar) (b) Registrar for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 22nd 1948, at 2.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 1948, to Jan 19 1948, and that I last saw him alive on Jan 19 1948.

Immediate cause of death	Duration
Coronary Thrombosis	3 hrs
Due to Chronic Myocarditis	5 yrs
Due to Senile Arteriosclerosis	yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James E. Atchinson M.D.
Address 1617 Park Ave Date signed 1-22-48

VS 150

X

G59289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G59289

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Mercy Hospital 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 4104 Parkside Drive
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Dukes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Margaret L. Dukes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 2, 1886

8. AGE: Years	Months	Days	If less than one day
61	11	19	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name John Dukes
13. Birthplace Eastern Shore, Md

MOTHER
14. Maiden Name Mary Benton
15. Birthplace Eastern Shore, Md

16 (a) Informant Mrs. Margaret Dukes
(b) Address 4104 Parkside drive

17 (a) Burial (b) Date thereof 1-24-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Balto

18 (a) Funeral director J. J. Luck
(b) Address 5305 Belford Rd.

19 (a) JAN 22 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 19 48, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 19 48 to Jan 21 19 48, and that I last saw h.. alive on Jan 21 19 48.

Immediate cause of death Coronary Thrombosis

Duration

Due to Cor. occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Frank A. Solano

Address Mercy Hosp Date signed 1/21/48

VS 139

C59290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C59290

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1725 E. Oliver St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1725 E Oliver St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John A. Schwarzkopf

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose L.
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Aug 2 1867

8. AGE: Years 80 | Months 5 | Days 18 | If less than one day: hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Retired

FATHER 12. Name Henry A. Schwarzkopf
13. Birthplace Balto

MOTHER 14. Maiden Name Maggie Sheffer
15 Birthplace Germany

16 (a) Informant Rose L. Schwarzkopf
(b) Address 1725 E. Oliver St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 23 48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd

18 (a) Funeral director The Riggel Bro
(b) Address 1800 E. Lombard St.

19 (a) JAN 22 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1948, at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8, 1946 to Jan. 20, 1948, and that I last saw him alive on Aug. 1, 1947.

	Duration
Immediate cause of death: Coronary Occlusion	Few minutes
Due to: Coronary Disease	Unknown
Due to: Arteriosclerosis	Unknown
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip Artzinius M. D.
Address 2942 E. Fayette St. Date signed 1/21/48

VS 150

SUBJECT TO APPROVAL OF MEDICAL EXAMINER H. J. Mullins, M.D.

G59291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

F G59291 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4671 Park Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4671 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elenora (Laura Strauss) Manning

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-4061

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John E.

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Nov. 12 1889

8. AGE: Years 58 | Months 2 | Days 11 9 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Bindery

11. Industry or business

FATHER 12. Name Adolph Strauss

13. Birthplace Germany

MOTHER 14. Maiden Name Margaret Durrbeck

15 Birthplace Balto.

16 (a) Informant Robert J. Manning

(b) Address 4671 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 24 48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Old Frederick Rd

18 (a) Funeral director The Dippel Bros.

(b) Address 1800 E. Lombard St.

19 (a) JAN 22 1948 (Date received by Registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1948 at 2:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1948 to Jan 21 1948 and that I last saw h[illegible] alive on Jan 21 1948.

Immediate cause of death Coronary Thrombosis — Duration 1/1/48

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm D Burket M. D.

Address 4803 Park Heights Ave Date signed 1/24/48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C59292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered C59292

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 257 HERRINS COURT. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME MRS. EMILY MEYER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife JOSEPH CASPAR
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/4/77

8. AGE: Years	Months	Days	If less than one day
70	5	16	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER 12. Name George Hummer
13. Birthplace Germany

MOTHER 14. Maiden Name Wolburgar Nisses
15. Birthplace Balto

16 (a) Informant Joseph C. Meyer
(b) Address 257 Herring Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 24 48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd

18 (a) Funeral director The Dippel Bros.
(b) Address 1800 Eastern Ave

19 (a) JAN 22 1948 (Date rec'd by registrar) Huntington Williams Asst. Reg.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/20 1948, at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/11 1948 to 1/20 1948 and that I last saw her alive on 1/20 1948

Immediate cause of death RESPIRATORY FAILURE — Duration

Due to CIRRHOSIS OF THE LIVER

Due to

Other Conditions GENERAL ARTERIOSCLEROSIS
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Lymphosarcoma - undetected pulmonary

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry J. Houska M.D.
Address 1 E. Lex. St. Date signed 1/20/48

V S 180

124 B

C59293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C59293

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physicians:- please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 N. Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(b) Street No. 1708 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph B. Hoeck

3 (b) If veteran, name war World War - 1

3 (c) Social Security Account No. 216-09-0889

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 23 - 1889

8. AGE: Years	Months	Days	If less than one day
58 59	11	28	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Henry J. Hoeck
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Margaret Barnes
15. Birthplace Balto. Md.

16 (a) Informant John P. Hoeck
(b) Address 1731 Daley Ave.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 1/24/48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway Williamsport

19 JAN 22 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 1948, at 8 a. M.

21. I certify that I took charge of the remains described above, held an insp.& inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Royer M.D.
Medical Examiner.

Date signed 1-21-48

VS 131

G59294
GM.

BALTIMORE CITY HEALTH DEPARTMENT
116744 CERTIFICATE OF DEATH 74a

G59294
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution: Baltimore City Hospitals 26-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1603 Elrino ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME [illegible] Bynion

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Emily

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10-1872

8. AGE: Years 75 | Months 4 | Days 10 | If less than one day ... hr. ... min.

9. Birthplace England
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk/
Location Taylor Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway Huntingtown Williams, M.D.

19 (a) JAN 29 1948 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-20-48, 1948, at 9.05P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-20-48 1948 to 1-20-1948, and that I last saw h... alive on 1-20-1948.

	Duration
Immediate cause of death: Pulmonary Edema	4 days
Due to: Arteriosclerotic Heart Disease	?
and Lymphatic Leukemia, sub	
Due to: acute	?
Other Conditions: Probable Uremia	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed 1-21-48

VS 150

G59295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G59295

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5005 Woodside Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 4
(d) Street No. 5005 Woodside Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Ida N. Buckingham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1867.

8. AGE: Years	Months	Days	If less than one day
80	9	6	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Wm. Buckingham
13. Birthplace Md.

MOTHER
14. Maiden Name Janett Peacock
15. Birthplace Md.

16 (a) Informant Mrs. J. F. Graves, (Niece)
(b) Address 5005 Woodside Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 24/48. (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Whittle
(b) Address 4101 Edmondson Ave.

19 (a) JAN 22 1948 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21, 1948, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10 1947, to 1-21 1948, and that I last saw her alive on 1-20 1948.

Immediate cause of death: Myocardial Insufficiency — Duration: 1 Year

Due to: Hypertension Cardio-Vascular Disease — Duration: 10 yrs?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilson K. Gallagher M.D. M. D.
Address Catonsville-28, Md. Date signed 1-22-48

VS 150

G59296

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

47c

Registered No. G59296

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 63 days
(e) Length of stay in Baltimore (yrs., mos., or days): 63 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: SC (b) County:
(c) City or town: Moultrieville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location):
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Edward Frank St. George

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Laura Larson St. George
6 (c) If alive, give age: ? years
7. Birth date of deceased (mo., day, yr.): Sept. 2, 1882
8. AGE: Years: 65 Months: 4 Days: 19 If less than one day: hr. min.
9. Birthplace: Southport, NC (Town, county, and state)
10. Usual Occupation: Master
11. Industry or business: Seafarer

FATHER
12. Name: John Newton St. George
13. Birthplace: NC

MOTHER
14. Maiden Name: Athelia Daniel
15. Birthplace: NC

16 (a) Informant: Records
(b) Address: US Marine Hospita

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan 25-48 (month) (day) (year)
(c) Cemetery or crematory Location: Wilmington N. Carolina

18 (a) Funeral director: Ellsworth Funeral
(b) Address: 3911 Liberty Heights Ave

19 (a) [illegible] (b) Huntington Williams Md

JAN 22 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 21 1948, at 4:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19 1947, to Jan. 21 1948, and that I last saw him alive on Jan. 21 1948.

Immediate cause of death: 1- Carcinoma, bronchiogenic, left main bronchus
Due to: 2- extention to adjacent left lung and tracheobronchial
Due to: lymph nodes
Other Conditions: 3- Pneumonia left lung with areas of atelectasis

Duration: ONE YEAR / / / / 5 days

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon
Address: Clinical Director Date signed: 1/22/48 M. D.

VS 150

X

G59297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G59297

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dot.
(c) Hospital or institution: South Balto General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1300 Andrea 37 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Adam Kozuch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant ?
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 22nd 1948 (month) (day) (year)
(c) Cemetery or crematory St. Matthews
Location Ohlenmeyer St. E'd

18 (a) Funeral director Leo G. Cook
(b) Address 1201-03 N. Patterson Park Ave

19 (a) [illegible] (b) Hunting for Williamsport

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/22 1948, at 7:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to h.s death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiac Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ causes of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. (Medical Examiner.)

Date signed 1/24/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C59298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. C59298

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2528 Guilford Ave.
(c) Hospital or institution: none 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore 8
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2528 Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Dorsey Polk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Mary M. Polk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1876

8. AGE: Years	Months	Days	If less than one day
71	7	2	hr. min.

9. Birthplace Sykesville, Md.
(Town, county, and state)
10. Usual Occupation U. S. Navy Dept.
11. Industry or business

FATHER
12. Name Trusten Polk
13. Birthplace Del.

MOTHER
14. Maiden Name Louisa Capron Dorsey
15. Birthplace Md.

16 (a) Informant Mary Louise Polk
(b) Address 2528 Guilford Ave.

17 (a) Burial (b) Date thereof 1/23/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) [illegible] (b) Williamsport, Md.
(Signature of Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 1948, at 8.00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1, 1947 to Jan. 21, 1948.
and that I last saw him alive on Jan. 14 1948.

Immediate cause of death: Myocardial Failure — Duration: 2 weeks
Due to: Coronary Artery Disease — Duration: Months
Due to:
Other Conditions: —
(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation: —
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Francis M. Oyler M. D.
Address 2701 N. Calvert St Date signed Jan. 22, 1948

VS 150

X

G59299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered G59299

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 101 E Mount St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 101 E Mount St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth Smyth

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife John Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 13 1881

8. AGE: Years	Months	Days	If less than one day
66	1	9	hr. min.

9. Birthplace Frederick Md (Town, county, and state)
10. Usual Occupation Cook.
11. Industry or business Church

FATHER
12. Name Henry McC Henry
13. Birthplace Thurmont Md

MOTHER
14. Maiden Name Catherine Crouse
15. Birthplace Thurmont Md

16 (a) Informant Blanche McC Henry.
(b) Address Frederick Md

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1/24/48 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cemetery
Location Frederick Md

18 (a) Funeral director C E Cline Funeral
(b) Address Frederick Md

19 (a) JAN 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/22 1948, at 7 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to h.c. death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C P Lubrecht M.D. Medical Examiner.
Date signed 1/22/48

VS 151

G59300 BC-48-01434

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1612

X G59300 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Joppa R.D. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Esther Jones
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 22, 1948
8. AGE: Years | Months | Days | If less than one day: 2 hr. newborn min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Kemp Jones
13. Birthplace N. C.

MOTHER
14. Maiden Name Esther Howell
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 24, 1948 (month) (day) (year)
(c) Cemetery or crematory Dove Grove
Location Harford Co Md
18 (a) Funeral director Howard K. McLyman Town
(b) Address Abingdon Md
19 (a) JAN 0 1948 (Date rec'd by registrar) (b) Huntington Willis Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1948 at 1 05A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death: Erythroblastosis fetalis — Duration 2 hrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Newton Long
Address The Johns Hopkins Hosp Date signed 1/22/48 M. D.

C59301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

Registered No. C59301

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Lombard Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22da
(e) Length of stay in Baltimore (yrs., mos., or days) 22days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. R. D. 5
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Joseph Bigham

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	married

6 (b) Name ~~of husband~~ or wife Jessie Barnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Farm

FATHER
12. Name not known
13. Birthplace

MOTHER
14. Maiden Name not known
15. Birthplace

16 (a) Informant Mrs. Jessie Bigham
(b) Address Westminster R.D. 5 Md

17 (a) Burial (b) Date thereof 11-25-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bethel Cemetery
Location Pipe Creek, Md.

18 (a) Funeral director H. H. Hartlove & Son
(b) Address Union Bridge, Md.

19 (a) Nov 23 1948 (b) Huntington Williams Md
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/22/48 19 , at 5 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 ,
and that I last saw h alive on 11/22/48 19 .

Immediate cause of death	Duration
Intestinal Obstruction	
Due to Carcinoma of Bladder	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J Brumbaugh M.D.
Address University Hosp Date signed 11-22-48

VS 153

659302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

659302 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 322 N. Pulaski st.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 0

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 322 N. Pulaski st.

(If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Ella Grace Rush

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	none

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband William F. Rush

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 19th 1856

8. AGE: Years	Months	Days	If less than one day
91	11	3	hr. min.

9. Birthplace Lancaster Pa.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER

12. Name George Troyer

13. Birthplace Lancaster Pa.

MOTHER

14. Maiden Name Unknown

15 Birthplace "

16 (a) Informant Everett C. Schroder

(b) Address 322 N. Pulaski St.

17 (a) Burial (b) Date thereof 1/26/48

(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Meadow Ridge

Location Dorsey Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul st.

19 JAN 23 1948 Huntington Williams M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22nd 1948, at 10 40 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 5 - 1947 to 1-22- 1948, and that I last saw her alive on 1-15- 1948.

Immediate cause of death	Duration
Organic Heart Disease	unknown
Due to	
Due to	
Other Conditions Hypertension	unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Chester Riland, M. D.

Address 2532 Edmondson Ave Date signed 1-22-48

VS 150

G59303 Ord 4

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 124a

G59303 Registered No. 360907

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27-17
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3010 Spaulding Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bernadine Lightner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife Charles E Lightner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 31, 1899

8. AGE: Years	Months	Days	If less than one day
48	2	22	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business None

FATHER
12. Name Joseph O'Brien
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 1-24-48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore

18 (a) Funeral director Leroy Boyers
(b) Address 5005 Park Heights Ave

19 (a) JAN 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-22 1948, at 600a M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-22 1948 to 1-22 1948 and that I last saw her alive on 1-22 1948.

Immediate cause of death	Duration
Hemorrhage	1wk
Due to esophageal varices	
Due to Laennecs cirrhosis	yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J A Sisson
Address Johns Hopkins Hosp Date signed 1-23-48 M.D.

X

G59304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G59304
Registered No.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. THIS CERTIFICATE WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2048 E. Fayette Street
(c) Hospital or institution: 6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2048 E. Fayette Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanley Hoult

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1884

8. AGE: Years	Months	Days	If less than one day
63	11	23	hr. min.

9. Birthplace England
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Guilford Folding Box

FATHER
12. Name ?
13. Birthplace England

MOTHER
14. Maiden Name ?
15 Birthplace England

16. (a) Informant Charles W. Oliss
(b) Address 2048 E. Fayette Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 1/24/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

JAN 23 1948 (Date rec'd by registrar) (b) [illegible] for Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21, 1948, at 9:30 A. M.

21. I certify that death occurred on the date above stated, that I attended deceased from 8 Jan 1948 to 20 Jan 1948 and that I last saw h[illegible] alive on 20 Jan 48

Immediate cause of death Coronary Thrombosis — Duration

Due to arteriosclerosis

Due to

Other Conditions Bronchial Asthma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David J. McGrath M. D.
Address 2939 W. Fredonyer St. Date signed 1-24-48

X

C59305 — 116540 — Registered No. C59305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 N. Calvert St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William P. Loihe (LOIHE)

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-01-4294

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26th 1897

8. AGE: Years	Months	Days	If less than one day
50	11	25	hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business American Radiator

FATHER
12. Name Peter Loihe (LOIHE)
13. Birthplace Russia

MOTHER
14. Maiden Name Julia ?
15. Birthplace Russia

16 (a) Informant Baltimore City Hospitals
(b) Address 49 40 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 JAN 23 1948 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21/ 1948 19 , at 11.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 13/ 1948 to Jan. 22 1948 and that I last saw h im alive on Jan. 21 1948

Immediate cause of death	Duration
Intracerebral Hemorrhage	
Due to Rupt. intracranial aneurysm	
Due to Arteriosclerosis, marked	
Other Conditions Hypertensive C-V. disease	

(Include pregnancy within 3 months of death)

Date of operation 1/21/48

Major findings of operation: intracerebral hematoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R.N. N. Crosby
Address Baltimore City Hosp Date signed 1/24/48

VS 150

83a

G59306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

G59306 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3019 Shannon Drive
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3019 Shannon Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F. Schmidt

3 (b) If veteran, name war: none

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife: Ada M. Schmidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 9, 1876

8. AGE: Years	Months	Days	If less than one day
71	5	13	hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation: Doorman
11. Industry or business: Mutal Track Room

FATHER
12. Name: Nicholas Schmidt
13. Birthplace: Germany

MOTHER
14. Maiden Name: Margaret (UNknown)
15 Birthplace: --

16 (a) Informant: Mrs. Alverta Kibbey
(b) Address: 309 N. Greenbrier

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 1/24/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: Baltimore, Maryland

18 (a) Funeral director: Wm. Cook, Inc.
(b) Address: 1217 St. Paul Street

19 (a) JAN 23 1948 (Date received by) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22, 1948, at 12:30 M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948, to Jan 22 1948, and that I last saw him alive on Jan 22 1948.

Immediate cause of death	Duration
Coronary occlusion	
Due to Arterio-Sclerosis	
Due to Auricular Fibrillation	
Other Conditions Cirrhosis of Liver — ascites — Chronic Nephritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter A. Anderson M. D.
Address 3601 Shannon Drive Date signed 1-23-48

VS 150

G59307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G59307
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4711 Hampnett Avenue
(c) Hospital or institution: 27-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4711 Hampnett Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph J. Heil

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife Elizabeth V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
79			hr. min.

9. Birthplace Port Deposit, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Rose Gleason
(b) Address 4711 Hampnett Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-23-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 JAN 23 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20, 1948, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to Jan 20 1948 and that I last saw h[illegible] alive on Jan 20, 1948

Immediate cause of death Bronchial pneumonia — Duration 3 days
Due to
Due to
Other Conditions Generalized arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter F. Kerkmann M. D.
Address 1016 S. East Ave Date signed 1/22/48

V S 150

C59308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

C59308 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1458 Patapsco St.
(c) Hospital or institution: 23-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) about 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1458 Patapsco St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Edith C. Noble

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife George Noble (deceased)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1887

8. AGE: Years	Months	Days	If less than one day
60	9	26	hr. min.

9. Birthplace Adams Co, Penna. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business —

FATHER
12. Name Rubin Noel
13. Birthplace Adams Co., Penna

MOTHER
14. Maiden Name Ellen Lightner
15. Birthplace Adams Co, Penna

16 (a) Informant Harry J. Noel (Bro.)
(b) Address 1458 Patapsco St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 24 1948 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Howard Co., Md.

18 (a) Funeral director C. Howard Evans
(b) Address 1400 N. Charles St.

19 JAN 23 1948 (Date rec'd by registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Wed. Jan. 21 1948 at 3:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 19 to 19 and that I last saw h[illegible] alive on Jan 20 1948.

Immediate cause of death [illegible] Embolism of Heart — Duration

Due to Mitral regurgitation of Heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. Latrobe Ewalt
Address 1945 N. Charles St Date signed 1/22/48 (M. D.)

VS 150

G. Latrobe Ewalt. x

659309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

659309 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 23-2
(b) Street address Calhoun & Fayette Sts
(c) Hospital or institution Franklin Sq. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Marshall Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country —

3 (a) FULL NAME George Alexander

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-05-8564

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna M. Alexander (Nee O'Neill) 6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Feb. 5, 1885

8. AGE: Years 62 | Months 11 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Sanding Machine Operator

11. Industry or business Locke-Insulator Co.

FATHER — 12. Name Charles Alexander
13. Birthplace Germany

MOTHER — 14. Maiden Name Fate (?)
15. Birthplace Germany

16 (a) Informant Mrs. Anna M. Alexander (Wife)
(b) Address 1616 Marshall Ave. Balto 39 Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mon. Jan 26 1948 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem. Co.
Location Anne Arundel Co., Md.

18 (a) Funeral director Geo. Howard Evans
(b) Address 1402 S. Charles St. Balto 30 Md.

19 (a) JAN 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1948 at 6:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 1948 to Jan 22 1948 and that I last saw him alive on Jan 21 1948.

Immediate cause of death Rupture of Thoracic Aortic Aneurism — Duration

Due to —

Due to —

Other Conditions Nephritis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

Of autopsy: As Above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Joseph B. Schrook M. D.
Address Franklin Sq. Hosp. Date signed Jan 22 1948

VS 150

G59310 M.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH. 13

G59310

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: altimore City Hospital 74-2

20 20 Days

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1474 Woodall ST.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Frank Folderauer

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-7991

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Rose Folderauer

6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) June 2 - 1904

8. AGE: Years	Months	Days	If less than one day
43	7	18	hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER

12. Name Fred

13. Birthplace Germany

MOTHER

14. Maiden Name Grace Jones

15. Birthplace Maryland

16 (a) Informant Records Balto. City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-24-48 (month) (day) (year)

(c) Cemetery or crematory Glen Haven

Location Glen Burnie

18 (a) Funeral director Charles F. Hill

(b) Address 1501 E. Fort Ave.

19 (a) JAN 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-20-48 1948, at 11.45 M

21. I certify that death occurred on the date above stated, that I attended deceased from 1-5-1948 to 1-20-1948

and that I last saw him alive on 1-20- 1948

Immediate cause of death	Duration
? Tuberculous meningitis	6 wks.
Due to Pulmonary tuberculosis bilateral, advanced	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature R. T. Benford M. D.

Address Balt. City Hosp. Date signed 1-20-48

X

G59311

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 170C

G59311 Registered No.

Please write PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital 20-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1920 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLA - A. - BECK

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-1565 B

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife J. Henry Beck
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Mar 13th 1874

8. AGE: Years	Months	Days	If less than one day
73	10	9	— hr. — min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Ferdinand Lautenbach
13. Birthplace Md.
14. Maiden Name Caroline L. Meyer
15. Birthplace Md.

16 (a) Informant J. Henry Beck
(b) Address 1920 W. Lexington St

17 (a) Burial (b) Date thereof Jan 24-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md.

18 (a) Funeral director F. A. Stapleton Son
(b) Address 1300 Eutaw Place

19 (a) JAN 23 1948 Huntington Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22, 1948, at 1.15 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Embolus, Cerebral Edema

Due to

Other Conditions Fract. Pelvis, Fract. of Rt. Arm & Rt. Scapula A.S.C.J. Bruises

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 6/3

(a) Date of injury 12-25-47 at ? M.
(b) Where did injury occur? Orleans (Fayette) & Collington Ave. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Passenger in car collision

23. Signature [signature] M.D.
Medical Examiner.
Date signed 1-22-48

VS-157

G59312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G59312
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2015 N. Payson St
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 N. Payson St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Henry Schneider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Atlanta
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) May 15th 1876

8. AGE: Years	Months	Days	If less than one day
71	8	9	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Sheet Metal Worker
11. Industry or business OWNER of Business

FATHER
12. Name Adam Schneider
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Virginia Klein
(b) Address 2015 N. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 23 Jan 48 (month) (day) (year)
(c) Cemetery or crematory Trinity
Location Baltimore - Md.

18 (a) Funeral director F. B. Wisbert & Son
(b) Address 1200 Eutaw Place - 17

19 (a) JAN 23 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20 1948 at 8:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8. 1947 to Jan 20 1948, and that I last saw h alive on Jan 20 1948.

Immediate cause of death	Duration
Chr. Myocarditis	1945
Due to Chr. Interstitial Nephritis	1945
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Brown M. D.
Address 162 W. North Ave Date signed

Dr. Brown. +

G59313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1248

Registered No. G59313

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 20-5
(b) Street address Madison St & Linden Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2618 St Benedict St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George F. Wannemacher

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Anna E. Wannemacher
6 (c) If alive, give age ✓✓ years

7. Birth date of deceased (mo., day, yr.) Sept 29 1891

8. AGE: Years	Months	Days	If less than one day
56	3	22	hr. — min. —

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business Restaurant - Owner

FATHER
12. Name Jefferson D. Wannemacher
13. Birthplace Richmond, Md

MOTHER
14. Maiden Name Mary Layfield
15. Birthplace Baltimore, Md

16 (a) Informant Anna E. Wannemacher
(b) Address 2618 St Benedict St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 24 /48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md

18 (a) Funeral director J. B. Shipley & Son
(b) Address 202 Eastern Place

19 (a) JAN 23 1948 (Date rec'd by registrar) (b) Huntington Hillsdale, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 Jan 1948, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 Jan 1948 to 20 Jan 1948 and that I last saw him alive on 20 Jan 1948

Immediate cause of death	Duration
Gastro intestinal Hemorrhage	1 day
Due to Cirrhosis of Liver	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Allan Spiel M.D.
Address Md. Gen. Hosp. Date signed 20 Jan 48

VS 150

G59314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48B

Registered No. G59314

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3206 W. Belvedere Ave
(c) Hospital or institution: 27-18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3206 W Belvedere Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fannie Coleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 53 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Lazar
13. Birthplace Russia

MOTHER
14. Maiden Name Rhoza
15. Birthplace Russia

16 (a) Informant Louis Coleman
(b) Address 3206 W Belvedere Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-25-48 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Boulevard

18 (a) Funeral director Jacob Lewis Inc
(b) Address 2160 Eutaw Place

19 (a) 1-23 1948 (Date rec'd by registrar) Hewitt for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-20- 1948, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1947 to Jan 23 1948, and that I last saw h.e. alive on Jan 20, 1948

Immediate cause of death: Respiratory failure — Duration: 3 days

Due to: secondary anemia

Due to: Diffuse adenocarcinomatosis of both uterus — 6 months

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation May 1947

Major findings of operation: adenocarcinoma of both uterus

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph R. Wyckoff M. D.
Address 515 St Paul Heights Ave Date signed 1/23/48

V S 150

C59315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. C59315

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayna Ave 15-3
(c) Hospital or institution West Balto Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 401 Westwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Strauss

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Kate Strauss

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Herman Strauss
(b) Address 3407 Woodbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-23-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 2400 Eutaw Place

19 JAN 23 1948 (Date rec'd by registrar) (Signature) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-22 1948, at 10:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-18- 1948 to 1-22 1948, and that I last saw h[illegible] alive on 1-22 1948.

Immediate cause of death	Duration
Cardiac arrest	
Due to Myocardial failure	
Due to Hypertension a.s. [illegible] disease	
Other Conditions Adenoma of thyroid (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Leedes M.D.
Address 1-23-48 Date signed

VS 150

× West Balto Genl

G59316

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 122a

G59316 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2528 W. Mosher St.
(c) Hospital or institution: 16-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2528 W. Mosher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ALBERT LAWRENCE MEUSEL

3 (b) If veteran, name war: WW #1
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife: Ruthetta P.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1894

8. AGE: Years	Months	Days	If less than one day
53	4	9	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Butter & Egg Business
11. Industry or business: Self

FATHER
12. Name: Arnulius Meusel
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Carolina Otter
15. Birthplace: Baltimore, Md.

16 (a) Informant: Ruthetta P. Meusel (wife)
(b) Address: 2528 W. Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/48 (month) (day) (year)
(c) Cemetery or crematory: Emmanuel
Location: Tyrone, Md.

18 (a) Funeral director: Wm. J. Tietjen & Sons, Inc.
(b) Address: Loch & Pa. Aves; Balto., Md.

19 (a) JAN 23 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: JAN. 20 1948 at 6.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2 1947 to Jan 20 1948, and that I last saw h/ m alive on Jan 20 1948.

Immediate cause of death: Coronary Thrombosis — Duration
Due to
Due to
Other Conditions: Left Hypnil Hemoplegia
(Include pregnancy within 3 months of death)
Date of operation Dec 8, 1947
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Thos E. Shannon M.D.
Address: 520 medical arts bldg Date signed: Jan 22, 48 M. D.

VS 130

X

G59317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

598

Registered No. G59317

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2208 South Rd.
(c) Hospital or institution: 27-15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2208 South Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL ARTHUR NATTANS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Inez C. G. Nattans
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1874

8. AGE: Years	Months	Days	If less than one day
73	2	6	hr. min.

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual Occupation Director
11. Industry or business Read Drug and Chemical Co.

FATHER
12. Name Arthur Nattans
13. Birthplace Alsace Lorraine

MOTHER
14. Maiden Name Dora Goodman
15 Birthplace Unknown

16 (a) Informant Mrs. Inez C. G. Nattans
(b) Address 2208 South Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21, 1948, at 11:57 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Jan 21 1948 and that I last saw him alive on Jan 21 1948

Immediate cause of death
Infectious Arthritis — Duration 2-3 yrs
Due to
Arthritis Deformans — 1 yr.
Due to
Other Conditions Senile Debility — 1 yr.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature ERWIN F. MAYER M.D.
Address 1 Lee Esplanade Date signed 1/21/48

X

G59318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

G59318

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address BALTIMORE 27-18
(c) Hospital or institution: 3709 HAYWARD AVE
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3709 HAYWARD AVE
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME JOSHUA FRANTZ

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: No

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife GEORGIA B. FRANTZ

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr) JAN 26, 1870

8. AGE: Years 77 | Months 11 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business

FATHER
12. Name CHARLES FRANTZ
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MARY JONES
15. Birthplace MARYLAND.

16 (a) Informant MRS. GEORGIA FRANTZ-(WIFE)
(b) Address 3709 HAYWARD AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1/23/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ DRUID RIDGE
Location PIKESVILLE, MD. (BALTO CO.)

18 (a) Funeral director W.M.J. TICKNER & SONS INC.
(b) Address NORTH & PA. AVES; BALTO., MD.

19 (a) JAN 23 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 20 1948, at 3:20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945 to Jan. 20 1948 and that I last saw him alive on Jan 19 1948.

Immediate cause of death Carcinoma of colon — Duration 3 yrs

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature W. H. Krenzer

Address 1402 E. Lanvale Date signed 1-22-48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C59319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C59319

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 12-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 N. Charles Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Whitridge Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31 1891

8. AGE: Years 56 | Months 5 | Days 21 | If less than one day hr. min.

9. Birthplace Oella. Md (Town, county, and state)

10. Usual Occupation Insurance

11. Industry or business Salesman

FATHER
12. Name Thomas H Whitridge
13. Birthplace Mass.

MOTHER
14. Maiden Name Mary Eden Bowie
15. Birthplace Prince Georges Co Md

16 (a) Informant Mrs Albert C Bruce
(b) Address 107 Charlcote Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 23 48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Green Mount
Location Oella, Md

18 (a) Funeral director Henry H. Jenkins & Bro
(b) Address McCulloh & Orchard Sts

19 (a) JAN 23 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21, 1948 at 1 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy & Inquiry thereon, and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions Generalized arterio-sclerosis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner.
Date signed 1-21-48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G59320 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert St.

(c) Hospital or institution: Mercy Hospital 27-15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Mount St. Agnes (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sister Mary Austin R. S. M. (Stonebraker)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1, 1893

8. AGE: Years	Months	Days	If less than one day
54	4	20	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Sister of Mercy

11. Industry or business

FATHER 12. Name J. Clagett Stonebraker

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden Name Laudie J. Thrasher

MOTHER 15. Birthplace Maryland

16 (a) Informant admitting face

(b) Address Mercy Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/48 (month) (day) (year)

(c) Cemetery or crematory Mt. St. Agnes

Location Mt. Washington

18 (a) Funeral director H. W. Meares and Son

(b) Address 505 N. Calvert St.

19 (a) JAN 23 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1948, at 4:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 1948, to Jan 21 1948 and that I last saw her alive on Jan 21 1948.

Immediate cause of death Coronary Thrombosis — Duration

Due to —

Due to —

Other Conditions Hypertension Cardiovascular disease (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Jane M. Finnigan

Address Mercy Hospital M. D. Date signed Jan 21

for Sr. Rose Hammer
Thomas J. Maddox, M.D.

659321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 659321

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Broadway
(c) Hospital or institution: John Hopkin's Hospital 15-12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3743 Park Heights Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jannie Brouner

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-22-5965

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Late Aaron

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-7-83

8. AGE: Years 64 | Months 10 | Days 19 | If less than one day ___ hr. ___ min.

9. Birthplace Lithuania (Town, county, and State)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Nachan Kutlan
13. Birthplace Lithuania

MOTHER 14. Maiden Name Sarah Hyatt
15. Birthplace Lithuania

16 (a) Informant Mrs Raphael Policakoff
(b) Address 3410 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 23/48 (month) (day) (year)
(c) Cemetery or crematory Herbert Rendale Cem
Location Hamilton ave Rendale

18 (a) Funeral director Sol LEVINSON & BROS
(b) Address 1124-26 W. NORTH AVE

19 (a) JAN 23 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-22-48, at 7.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19 1948 to 1-22 1948.
and that I last saw her alive on 1-22 1948.

Immediate cause of death
complete heart block
Due to arteriosclerotic heart
Due to disease

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration
yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. A. Sisson
Address Johns Hopkins Hosp. Date signed 22 Jan 48

VS 150

CURE

059322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 059322

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.U.H.
(c) Hospital or institution: Providence Hospital 151

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1536 Woodyear St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Cure

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife Elliott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
96			hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Margaret Lane
(b) Address 1536 Woodyear St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/26/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Wm. H. Kelson
(b) Address 1303 Pressman St

19 (a) JAN 23 1948 (Date rec'd by registrar) (b) Hunterton Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/22 1948 at 5:24 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to h.c. death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic CV disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D. P. Salamanca M.D.
Medical Examiner.
Date signed 1/22/48

VS 191

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G59323 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 862 Washington Blvd.
(c) Hospital or institution: 2-1-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 862 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas W. Hohn

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Florence E. Hohn
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) April 30, 1882

8. AGE: Years	Months	Days	If less than one day
65	8	21	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Ice Business
11. Industry or business Self

FATHER
12. Name Thomas Hohn Sr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Unknown
15 Birthplace Unknown

16 (a) Informant Mrs Florence E. Hohn
(b) Address 862 Washington Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 24, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore

18 (a) Funeral director Frederick A. Dole
(b) Address 1200 W. Lombard St

19 (a) (Date filed) JAN 23 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21, 1948, at 2:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 1948 to Jan 21 1948, and that I last saw h— alive on Jan 21 1948.

Immediate cause of death	Duration
Acute Heart Failure	1 day
Due to —	
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lorenz Hahn M.D.
Address 876 Ave Date signed 1/24/48

V S 150

X 1

659324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 659324

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3009 Herbert St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3009 Herbert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Werner

3 (b) If veteran, name war: W. War #1

3 (c) Social Security Account No. 219-16-7860

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 14 1889

8. AGE: Years 58 | Months 5 | Days 7 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name George Werner
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Frank Malle
(b) Address 181 W. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 24 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Balto Md

18 (a) Funeral director Pott & B. M. Walter
(b) Address Pott & Shriver Co

19 (a) JAN 23 1948 (Date rec'd by registrar) (b) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 1948, at 11 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/20 1948 to 1/21 1948, and that I last saw him alive on 1/20 1948.

Immediate cause of death: Coronary Thrombosis
Repeated attacks — Duration: 1 yr.

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Morrison, M. D.
Address 11 E. Chase St Date signed 1/22/48

VS 150

659325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 659325

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3705 Second St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dan Griffith Vanderoook

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Pauline Hopkins Vanderoook

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) April 5, 1896

8. AGE: Years 51 | Months 9 | Days 17 | If less than one day ..... hr. ..... min.

9. Birthplace Michigan
(Town, county, and state)

10. Usual Occupation CBM

11. Industry or business Coast Guardsman

FATHER
12. Name Henry Vanderoook
13. Birthplace Michigan

MOTHER
14. Maiden Name ? Griffith
15. Birthplace Michigan

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 26-1948 (month) (day) (year)
(c) Cemetery or crematory Arlington Nat'l Cem
Location Arlington Virginia

18 (a) Funeral director Pvt C.S.B.M. Walter
(b) Address Peach Street Ga

JAN 29 1948

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22 1948, at 7:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 14 1948 to Jan. 22 1948, and that I last saw him alive on Jan. 22 1948.

Immediate cause of death Myocardial infarction — Duration 8 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 1/22/48

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Q59326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. Q59326

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 461 S. Brunswick St
(c) Hospital or institution: 20-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 461 S. Brunswick St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Dahl

3 (b) If veteran, name war: None | 3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: Elsie Dahl

6 (c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): March 22-1884

8. AGE: Years 63 | Months 10 | Days 0 | If less than one day: hr. min.

9. Birthplace: Balto Md (Town, county, and state)

10. Usual Occupation: None

11. Industry or business:

MOTHER / FATHER

12. Name: Henry Dahl

13. Birthplace: —

14. Maiden Name: Annie Dasehach

15. Birthplace: Md

16 (a) Informant: Elsie Dahl

(b) Address: 461 S. Brunswick St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan 26-1948 (month) (day) (year)

(c) Cemetery or crematory: Loudon Park

Location: Balto Md

18 (a) Funeral director: Roff & B.M. Walter

(b) Address: Pratt & Stricker Sts

19 (a) JAN 23 1948 (Date rec'd by Registrar) (b) Washington for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22 1948, at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1948 to Jan 22 1948, and that I last saw it alive on Jan 22 1948.

Immediate cause of death	Duration
Acute Heart Failure	1 day
Due to Myocardial Failure with Decompensation	2 wks
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Louis J. Sloan M. D.

Address 876 Wilson Blvd Date signed

VS 150

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

659327 — 82375

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. 659327

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
4 - 6 - 20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 N. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June ? 1842

8. AGE: Years	Months	Days	If less than one day
105	7		hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-24-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location R. I. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

JAN 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22nd 1948, at 2.15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 2/ 1943, to Jan. 22 1948 and that I last saw h[im] alive on Jan. 22/1948.

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	years
Due to Generalized Arterio-sclerosis	years
Due to	
Other Conditions Malnutrition	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr M. D.

Address Baltimore City Hosp Date signed 1-22-48

VS 150

659328 ✓

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. 659328

Va. 16148

CERTIFICATE OF DEATH 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution: Baltimore City Hospitals 10-1

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-2-27 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town BBaltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1010 Nursery Alley
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Sutton

3 (b) If veteran, name war

3 (c) Social Security Account No. Widow

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1887

8. AGE: Years 60 | Months | Days | If less than one day ... hr. ... min.

61

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Philip Dailey

13. Birthplace Va.

MOTHER 14. Maiden Name Minerva

15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 25 48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location B. & O. Co

18 (a) Funeral director Rayner Sanders

(b) Address 1112 E. Preston St

19 JAN 23 1948 (b) Washington Williams Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21/1948 19 ..., at 8.15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 24/1927 to Jan. 21 1948 and that I last saw h. or alive on Jan. 21/1948.

Immediate cause of death	Duration
Respiratory failure	
Cardiac failure.	
Due to Hypertensive Cardio Vascular Disease	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature R. T. Burford M. D.

Address Balt. City Hosp. Date signed 1-22-48

VS 150

X

C59329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C59329

93c

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Granite (If outside city or town limits, write RURAL and give town)
(d) Street No. Old Court Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LUTHER DUVALL

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-01-7202

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Gertrude Duvall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1911

8. AGE: Years	Months	Days	If less than one day
36	10	11	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Wilson Duvall
13. Birthplace Md.

MOTHER
14. Maiden Name Lillian Johnson
15. Birthplace Md.

16 (a) Informant Gertrude Duvall
(b) Address Granite Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-24-48 (month) (day) (year)
(c) Cemetery or crematory St Alphonsus
Location Woodstock Md

18 (a) Funeral director P.C. Hyinkelthorn
(b) Address Ellicott City Md

19 JAN 23 1948 (Registered by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21, 1948, at 9.30 P M

21. I certify that I took charge of the remains described above, held an insp.& inq. Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Embolism - Duration - Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer, M.D. Medical Examiner
Date signed 1-22-48

G59330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94B

Registered No. 59330

Please write PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2706 Boone Street
(c) Hospital or institution: 9-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2706 Boone Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EUGENE T. TRUELOVE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sarah J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation City Employee
11. Industry or business

FATHER
12. Name Geo. R. Truelove
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary J. Manning
15. Birthplace New York

16 (a) Informant Mrs. Eugene T. Truelove
(b) Address 2706 Boone Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location City

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREENMOUNT AVE & 22ND

19 (a) JAN 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 193

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/20/48 19 , at 8:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 20, 1948 to Jan. 20, 1948. and that I last saw him alive on Jan. 20, 1948.

Cause of death	Duration
Immediate: Angina Pectoris	
Due to: ------- -------	
Due to: 0----------	
Other Conditions: ----------	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jas. W. Fitzgerald M.D.
Address 401 E. 25th. St. Date signed 1/23/48.

Howard J. Mullen, M.D.

G59331

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

47a

Registered G59331

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Ln.
(c) Hospital or institution: Home for the Aged Town
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town 332 E. FEDERAL St. (If outside city or town limits, write RURAL and give town)
(d) Street No. 7 BALTO. MD (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Gordon (KATHARYN M. GORDON)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1881

8. AGE: Years	Months	Days	If less than one day
66	7	18	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George Gordon

13. Birthplace

MOTHER 14. Maiden Name Catha. Mahoney

15. Birthplace

16 (a) Informant Lillie Lisby 2nd Daur.

(b) Address 1200 Valley Ln.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1-24-48 (month) (day) (year)

(c) Cemetery or crematory CATHEDRAL

Location CITY

18 (a) Funeral director WIEDEFELD & SON

(b) Address GREENMOUNT AVE 22ND

19 (a) JAN 23 1948 (Date rec'd by registrar) (b) Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21 1948, at 12:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947, to Jan 21 1948, and that I last saw h.er alive on Jan 20 1948.

Immediate cause of death	Duration
Carcinoma Larynx	2 yrs
Due to	
Due to	
Other Conditions. Carcinomatosis	2 months

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.

Address 1631 E. North Ave Date signed 1/21/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

059832

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. 059832

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St & Linden Ave 13-6
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 716 W. 34th St # 11
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John William Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Nellie I. Stewart
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) April 28, 1884

8. AGE: Years	Months	Days	If less than one day
63	8	22	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Car Inspector
11. Industry or business Penn R. R.

FATHER
12. Name John W Stewart
13. Birthplace Md

MOTHER
14. Maiden Name Eliza J. Frederick
15. Birthplace Md

16 (a) Informant Nellie I Stewart,
(b) Address 716 W 34th St.

17 (a) Burial (b) Date thereof Jan 26, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Kenworthy & Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) JAN 23 1948 (b) Huntington Williams
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Jan 1948, at 9 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 16 Jan 1948 to 22 Jan 1948 and that I last saw h alive on 22 Jan 1948.

Immediate cause of death	Duration
Cardiac Failure	6 days
Due to Arteriosclerotic Cardio Vascular Disease	10 yrs
Due to	
Other Conditions Atypical Pneumonia	4 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Allan Spies M.D.
Address Md. Gen. Hosp. Date signed 22 Jan 48

G59333

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

124 a

Registered No. G59333

PRINT OR WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12-2
(c) Hospital or institution: Mercy Hospital, Balto.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2941 St Paul St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Francis S. Manchester

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-7486

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Eleanor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 8-1886

8. AGE: Years	Months	Days	If less than one day
61	4	14	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Bartender
11. Industry or business

FATHER
12. Name Andrew Manchester
13. Birthplace Pittsburgh Pa

MOTHER
14. Maiden Name Catherine Boyle
15. Birthplace Pittsburgh Pa

16 (a) Informant Eleanor Manchester
(b) Address 2941 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 26-1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location 4430 Belgian Road

18 (a) Funeral director Joseph Farace Inc
(b) Address 2227 Greenmount Ave

19 (a) JAN 28 1948 (Date rec'd by registrar) (Burlington Williams, M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-22 1948, at 2 23 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-17 1948, to 1-22 1948, and that I last saw him alive on 1-22 1948.

Immediate cause of death Coronary occlusion, anterior & Myocardial infarction — Duration
Due to Arterio sclerotic Heart disease
Due to
Other Conditions Mild Cirrhosis of Liver
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. L. Jamison M. D.
Address Univ. Hosp. Balto Md Date signed 1-22-48

VS 159

93 D

G59334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G59334 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2413 N. Gilmor St.
(c) Hospital or institution: 13-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2413 N. Gilmor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: William H. Gardner

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4 Sex: Male | 5 Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hannah F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5 1880

8. AGE: Years 67 | Months 7 | Days 17 | If less than one day hr. min.

9. Birthplace Gloucester, Va. (Town, county, and state)

10. Usual Occupation Custodian

11. Industry or business

FATHER
12. Name John A. Gardner
13. Birthplace Gloucester, Va.

MOTHER
14. Maiden Name Annie Williams
15. Birthplace Gloucester, Va.

16 (a) Informant Hannah F. Gardner
(b) Address Gloucester, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 24 1948 (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Gloucester, Va.

18 (a) Funeral director Geo. H. Stallard
(b) Address 1631 Druid Hill Ave.

19 (a) JAN 23 1948 (Date rec'd by Registrar) (b) Washington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Jan 1948; at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 20 Jan 1948 to 22 Jan 1948, and that I last saw h[im] alive on 21 Jan 1948.

Immediate cause of death Coronary Thrombosis — Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Blanchett A Jr

Address 1213 Madison Date signed 2-3-48

VS 150

659335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. 659335

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 9 Beechdale Rd

(c) Hospital or institution: at home 2-14

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltotcity

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 9 Beechdale Rd (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) **FULL NAME** John George Price Jr.

3 (b) If veteran, name war none

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widow

6 (b) Name of husband or wife Edith Rusk Price

6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) Oct 11 1865

8. AGE: Years	Months	Days	If less than one day
82	3	11	____ hr. ____ min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation retired

11. Industry or business Insurance

FATHER 12. Name John G. Price

13. Birthplace Baltimore

MOTHER 14. Maiden Name Anna Winkey

15. Birthplace Canada

16 (a) Informant Mrs Anna Y. Weaver (niece)

(b) Address 3619 Crookland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-24-48 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore

18 (a) Funeral director Shivadin Mortuary

(b) Address 108 W Franklin

19 (a) JAN 23 1948 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22 1948, at 3:18 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1939 to Jan 22 1948 and that I last saw h— alive on Jan 17 1948.

Immediate cause of death: Cerebral arteriosclerosis — Duration: 5 years

Due to: Prostatic obstruction — 6 mo

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Frances W Gluck M. D.

Address 3406 St Paul St Date signed 1/23/48

G59336

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G59336
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital | F-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) BOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1058 W Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Crane operator
11. Industry or business Sparrows Point Md

FATHER
12. Name Mr William Brown.
13. Birthplace N.C.

MOTHER
14. Maiden Name Elizabeth Ray
15. Birthplace N.C.

16 (a) Informant Nora Brown (Wife)
(b) Address 1058 W Fayette st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 26th 48 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cemetery
Location Baltimore Md

18 (a) Funeral director Elroy Oldham
(b) Address 1000 Brantley St.

19 (a) JAN 23 1948 (Date rec'd by registrar) (b) Huntington Hill Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23 1948, at 3:10 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Hypertension C.V. Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner
Date signed 1-23-48

X

659337

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

118

Registered No. 659337

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1729 Orleans St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1729 Orleans St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Victoria Keys

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fel.	Col	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 12-1898

8. AGE: Years	Months	Days	If less than one day
49	11	8	hr. min.

9. Birthplace King Queen Co. Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

MOTHER / FATHER

12. Name Lewis Lockley

13. Birthplace King Queen Co Va.

14. Maiden Name Jennie Gershian

15 Birthplace King Queen Co Va

16 (a) Informant Robt C West

(b) Address 1729 Orleans St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 24-48 (month) (day) (year)

(c) Cemetery or crematory West Point Va

Location West Point Va

18 (a) Funeral director Elroy B. Wilson

(b) Address 1000 Brantly Ave

19 (a) Date received 1948 Registrar for Williamsburg Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1948, at 9:50 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-12 1948 to 1-20 1948 and that I last saw h[illegible] alive on 1-20 1948.

Immediate cause of death	Duration
(a) Acute Dilatation of Heart	1 d
Due to (b) Acute Catarrhal Pneumonia	10 d
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. L. Berry

Address 1420 E. Chase Date signed Jan 22-48 M.D.

X

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. G59338

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 19-4
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 W. Pratt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH A WHITE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28 1929

8. AGE: Years	Months	Days	If less than one day
18	7	20	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name Leo M Whyte
13. Birthplace Md

MOTHER
14. Maiden Name Nellie A Duggan
15. Birthplace Ireland

16 (a) Informant Lev M Whyte
(b) Address 1811 W Pratt st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-48 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Balto Md

18 (a) Funeral director Geo A Farley
(b) Address Fulton & Lafayette

19 (a) JAN 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH January 22 1948, at 11:29 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to

Other Conditions Arteriosclerosis of heart ~J.M.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L Royer M.D.
(Medical Examiner)
Date signed 1-23-48

VS 151

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59339

GM. 116098 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 494 0 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 19-2 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 W. Fayette ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Lewis Hipsley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Sep.

6 (b) Name of husband or wife James Hipsley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24 - 1872

8. AGE: Years	Months	Days	If less than one day
75	2	27	hr. min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Gideon Williams (D)
13. Birthplace N.C.

MOTHER 14. Maiden Name Rose Anna
15. Birthplace N.C.

16 (a) Informant Records Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 23 1948 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Baltimore

18 (a) Funeral director Chas. A. Feeley
(b) Address Fayette & Fulton Ave

19 (a) JAN 23 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 -20- 1948, at 3.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-24 - 1947 to 1-20-48 1948, and that I last saw h OR alive on 1-20- 1948.

Immediate cause of death Cardiac failure — Duration 1 hr

Due to HCVD — yrs

Due to

Other Conditions Fracture neck of femur left — 3 wks

(Include pregnancy within 3 months of death)

Date of operation 1/19/48

Major findings of operation: none

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 19-2
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 12/24/47 at 11:30 P M
(c) Where did injury occur? Balt. Balt Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Fell to floor at home

23. Signature Gordon Craft M. D.
Address Balt City Hosp Date signed 1/23/48

For S. C. J. Davis, by X
Howard J. Mercer, M. D.

G59340

BALTIMORE CITY HEALTH DEPARTMENT

BC - 48.01284 CERTIFICATE OF DEATH 1576

Registered No. G59340

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2225 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7259 Holabird Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Lowery James Alvin Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 21 - 1948

8. AGE: Years	Months	Days	If less than one day
		1	22 hr. 10 min.

9. Birthplace Bon Secours Hosp
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Alvin Lowery.
13. Birthplace [redacted]

MOTHER
14. Maiden Name McLee, Francis
15. Birthplace Sparrows Point Md.

16 (a) Informant James A Lowery
(b) Address 7259 Holabird Ave

17 (a) Burial (b) Date thereof 1-23-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn
Location Balto Md

18 (a) Funeral director George A Fuhrman
(b) Address Fulton Ave & Fayette

19 (a) (Date received) JAN 23 1948 Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1948, at 7:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 1948 to Jan 22 1948, and that I last saw him alive on Jan 22 1948.

Immediate cause of death	Duration
Condition of failure	
Due to Post. cardiac anomaly	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. F. Kane M. D.

Address Bon Secours Hosp Date signed

G59341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. G59341

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 8128 Dundalk Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK E. ISABELLA

3 (b) If veteran, name war: No

3 (c) Social Security Account No.:

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mrs. Anna Isabella

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1902

8. AGE: Years 45 Months 5 Days 24 If less than one day ____ hr. ____ min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Chipper

11. Industry or business Ship Building

MOTHER / FATHER

12. Name Thomas Isabella

13. Birthplace Italy

14. Maiden Name Antonette Marra

15. Birthplace Italy

16 (a) Informant Mrs. Anna Isabella

(b) Address 8128 Dundalk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 26, 1948 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart Cemetery

Location German Hill Rd

18 (a) Funeral director Roland L. Fisher

(b) Address 2112 Dundalk Ave.

19 (a) Date rec'd by Registrar JAN 28 1948 (b) Huntington Williams M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/22 1948, at 7:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/26 1947 to 1/22 1948 and that I last saw him alive on 1/21 1948

Immediate cause of death: Extra Cranial Hemorrhage

Due to: Sustained in Pre Frontal Lobotomy

Due to:

Other Conditions: Metastatic Carcinoma From Large Intestine to Pelvis

(Include pregnancy within 3 months of death)

Date of operation 1/13/48

Major findings of operation: Pre Frontal Lobotomy Carcinoma

of autopsy: Edema of Brain, Cancer in Pelvis

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ____ at ____ M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature George W. Mohler M. D.

Address Church Home + Hosp Date signed 1/22/48

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

59342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 59342

59342

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Darlington
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie S. KNIGHT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife R. Bernard Knight

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 11, 1884

8. AGE: Years	Months	Days	If less than one day
63	11	11	hr. min.

9. Birthplace Harford Co. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Samuel T. Smith
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Elizabeth McConnell
15. Birthplace Cecil Co. Md.

16 (a) Informant Edward Knight
(b) Address Darlington, Md.

17 (a) Burial (b) Date thereof 1/25/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Darlington
Location Darlington, Md.

18 (a) Funeral director Hubert P. Harkins
(b) Address Delta, Pa.

JAN 23 1948 (Harrington Williams, M.D.)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22 1948, at 3:55 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Subdural hemorrhage, with compression of brain.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-19-48 at P M.
(b) Where did injury occur? Darlington, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Hit on head with basketball

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 1/23/48

VS 151

X 468

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G59343

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1019. Stiles
(c) Hospital or institution: 3-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1019. Stiles St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Scagnelli

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Paul Scagnelli

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22 1868

8. AGE: Years 79 80 | Months 2 | Days 6. 26 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Lavagna

13. Birthplace Italy

MOTHER 14. Maiden Name Unknown

15. Birthplace Italy

16 (a) Informant Clemintine Biggis

(b) Address 1019. Stiles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 24 1948 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road.

18 (a) Funeral director Wendell J. Stippel

(b) Address 212. E. Hoffman St.

19 (a) JAN 23 1948 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1- 21- 1948 at 6 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8- 1- 1947 to 1- 21- 1948, and that I last saw h[illegible] alive on 1- 21- 1948

Immediate cause of death Exhaustion — Duration 2 months

Due to Dehydration — 2 mo

Due to Coma & age — 4 mo

Other Conditions + rupture of leg & hip - on fall

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 3/2

(a) Accident, suicide, or homicide accident

(b) Date of occurrence 8-1-47 at 9 30 P.M.

(c) Where did injury occur? 1019 Stiles Street (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No

(e) Means of injury Fall Down Stairs

23. Signature S. Scagnelli M. D.

Address Medical Arts Bldg Date signed

Howard J. Mueller, M.D.

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

G59344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G59344

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene Sts.

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Howard

(c) City or town Ellicott City (If outside city or town limits, write RURAL and give town)

(d) Street No. College Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Mettie Morris

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 57 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Richmond, Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Domestic

MOTHER / FATHER

12. Name Dan Morris

13. Birthplace Virginia

MOTHER

14. Maiden Name ? Morris

15. Birthplace Virginia

16 (a) Informant Mrs. Fannie Knight

(b) Address Ellicott City, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 24, 1948 (month) (day) (year)

(c) Cemetery or crematory Good Shepherd Cemetery Location Ellicott City, Maryland

18 (a) Funeral director Easton & Sons

(b) Address Ellicott City, Maryland

19 (a) JAN 23 1948 (Date rec'd by registrar) (b) Washington Funeral Home, Inc. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1948, at 3:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 1948 to Jan 21 1948 and that I last saw her alive on Jan 21 1948.

Immediate cause of death Coronary Occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature R. C. Duvall Jr. M. D.

Address University Hosp. Date signed Jan 21

VS 150

G59345 Gise ✓ X G59345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 587

Registered No.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Redwood Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Oella (If outside city or town limits, write RURAL and give town)
(d) Street No. 49 Oella Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Vera Gise ✓

3 (b) If veteran, name war None

3 (c) Social Security Account No. 215-28-5153

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 21, 1931

8. AGE: Years 16 | Months 2 | Days 1 | If less than one day hr. min.

9. Birthplace Ellicott City Howard Co. Md. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Grocery Store

FATHER 12. Name Ernest W. Gise

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Bertha Frederick

15. Birthplace Ellicott City, Md.

16 (a) Informant Mr. Ernest W. Gise

(b) Address 49 Oella Ave. Oella, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 26 1948 (Month) (day) (year)

(c) Cemetery or crematory Good Shepherd Location Ellicott City, Md.

18 (a) Funeral director Easton Sons

(b) Address Ellicott City, Md.

19 (a) JAN 23 1948 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/22/48 19 , at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/17/48 19 , to 1/22/48 19 , and that I last saw h— alive on 1/22/48 19 .

Immediate cause of death	Duration
Heart failure	
Due to Rheumatic Pan-Carditis	
Due to	
Other Conditions Pulmonary Infarct (at lower and middle lobes)	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Seen & Signed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. H. Donnelly Jr.

Address Univ. Hospital Date signed 1/23/48 M. D.

X

No. G59346

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 157a

Registered No. G59346

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22nd & Calvert Sts.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City, Route 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Brian Joseph Redmond

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/21/47

8. AGE: Years	Months	Days	If less than one day
0	8	0	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Joseph W. Redmond
13. Birthplace Maryland

MOTHER
14. Maiden Name Ann Todd
15. Birthplace England

16 (a) Informant Father
(b) Address Same.

17 (a) (Burial, cremation, or removal) **(b) Date thereof** (month) (day) (year)
(c) Cemetery or crematory
Location

Johns Hopkins Medical School JAN 23 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) JAN 23 1948 (Date rec'd by registrar) **(b)** Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21 1948, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1948 to Jan 21 1948 and that I last saw him alive on Jan 21 1948.

	Duration
Immediate cause of death Interval Hydrocephalus, congenital with spasticity	7 mos.
Due to Cerebral Atrophy, congenital	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 2/6/48
Major findings of operation: Cerebral Atrophy.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gary Martin Fox M.D.
Address Union Memorial Hosp. Date signed 1/21/48

VS 150

059347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. 059347

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 124 W. Mosher street
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 124 W. Mosher
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME AGNES KILLALEA

3 (b) If veteran, name war: -----

3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Single

6 (b) Name of husband or wife ----
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1878

8. AGE: Years	Months	Days	If less than one day
70	--	18	hr. min.

9. Birthplace Pikesville, Maryland
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Thomas A. Killalea
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Barron
15. Birthplace Ireland

16 (a) Informant Miss Mary Katherine Reardon
(b) Address 124 W. Mosher street

17 (a) Burial (b) Date thereof 1/24/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas J. Evans & Son Inc
(b) Address 847 N. Mt. Royal Ave

19 (a) JAN 23 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22 19 48 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2/48 19 to 1/22 19 48, and that I last saw h[illegible] alive on 1/21/48 19 .

Immediate cause of death: Myocardiac

Due to: Hypertension

Due to: Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
unknown

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilbur T. Downs
Address 401 Edmondson Date signed 1/23/48 M.D.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G59348 GM. 115808 — Registered No. G59348

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) 17 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1230 Ashland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Simon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Mary Simon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29 1903

8. AGE: Years	Months	Days	If less than one day
44	4	22	hr. min.

9. Birthplace S.C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER — 12. Name William Simon
FATHER — 13. Birthplace S.C.

MOTHER — 14. Maiden Name Mary Canty
MOTHER — 15. Birthplace S.C.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan 24 1948 (month) (day) (year)
(c) Cemetery or crematory Manning S. C
Location

18 (a) Funeral director Mrs Bessie Gaines
(b) Address 1408 Ashland ave

19 (a) JAN 24 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-20-48 1948 at 3.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1947, to 1-20-1948, and that I last saw him alive on 1-20-48 1948.

Immediate cause of death Pulmonary Tuberculosis (Far adv.) — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edmund Beacham M. D.
Address Balto City Hosp Date signed Jan 23 48

VS 150

Edmund Beacham X

059349 RUMIE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No. 059349

PRINT IN WHITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State S. C. (b) County
(c) City or town Monterey Columbia
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexandra Rumie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~ Joseph Rumie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-17-10

8. AGE: Years 37 | Months 10 | Days 10 | If less than one day hr. 10 min.

9. Birthplace Syria
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name Elias Faklani
13. Birthplace Syria

MOTHER
14. Maiden Name Matilda Zureak
15. Birthplace Syria

16 (a) Informant Elizabeth K. Rumie
(b) Address Cliffside Park N.J.

17 (a) Cremation (b) Date thereof 1/24/48
(Burial, cremation, or removal) (month) (day) (year)
(c) ~~Cemetery~~ or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) JAN 24 1948 (b) Huntington Williamsport, Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-22-48 at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-48 to 1-22-1948.
and that I last saw h[illegible] alive on 1-22-1948.

Immediate cause of death: Hypernephroma — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J.M. McCay (Ass. Res.) M. D.
Address Johns Hopkins Hosp. Date signed 1/22/48

VS 150

059350

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

97

Registered No. 059350

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2274 Druid Park Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2274 Druid Park Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas L. George

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Aurelia George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 15th 1881

8. AGE: Years	Months	Days	If less than one day
66	5	7	hr. min.

9. Birthplace Greece
(Town, county, and state)
10. Usual Occupation Tradesman
11. Industry or business Own

FATHER
12. Name Thomas L. George
13. Birthplace Greece

MOTHER
14. Maiden Name Elizabeth (Unknown)
15. Birthplace Greece

16 (a) Informant: Aurelia George
(b) Address 2274 Druid Park Drive

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 1/24/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location " Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) JAN 24 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22nd 1948, at 8 45' A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 9 1943 to Jan. 22 1948, and that I last saw him alive on Jan 19 1948.

Immediate cause of death Leukemia — Duration 2 weeks

Due to Atherioscleratic Gangrene of Rt foot

Due to Generalized Arteriosclerosis

Other Conditions Old Apoplexy
Left leg amputated for Gangrene
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis V Blum M. D.
Address 2310 Eutaw Pl Date signed 1/23/48

VS 150

X

G59351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G59351 Registered No.

PRESS WHITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3503 Greenmount Ave
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore 55 10 23 (Life)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3503 Greenmount Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ollie Johnson Kitchen

3 (b) If veteran, name war X

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife J. Claude Kitchen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 1st 1890

8. AGE: Years	Months	Days	If less than one day
57	10	22	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business Own Home

FATHER
12. Name John V. Johnson
13. Birthplace Holland

MOTHER
14. Maiden Name Teresa Westrik
15. Birthplace Holland

16 (a) Informant J. C. Kitchen
(b) Address 3503 Green Mount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/26/48 (month) (day) (year)
(c) Cemetery U. S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) JAN 24 1948 (Date rec'd by registrar) (b) Huntington Willis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23 1948 at 4.45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 8 1947 to Jan. 23 1948 and that I last saw her alive on Jan. 22 1948.

Immediate cause of death	Duration
Coronary occlusion	12 hours
Due to Hypertension	2 years
Due to Myocarditis	2 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Charles E. Baggott M. D.
Address 3812 Greenmount Ave Date signed Jan. 23 48

V S 150

659352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

477

Registered No. 659352

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3229 Esther Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3229 Esther Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George P. Hasenei

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widow

6 (b) Name of husband or wife Marie Hasenei
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 11 1883

8. AGE: Years	Months	Days	If less than one day
64	5	11	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Gen Laborer
11. Industry or business

FATHER
12. Name Geo Hasenei
13. Birthplace Balto

MOTHER
14. Maiden Name Dont Know
15. Birthplace Balto

16 (a) Informant Mrs Lizzie Albus
(b) Address 3229 Esther Pl.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 26 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem City
Location

18 (a) Funeral director Willard Funeral Home
(b) Address 2108 Nelson Or

19 (a) JAN 24 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1948 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1945 to Jan 22 1948 and that I last saw h alive on Jan 1st 1948.

Immediate cause of death Carcinoma of left lung — Duration 2yrs +

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death) Electrocoagulation

Date of operation 1945

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George D. Lefty M. D.
Address 4301 Belleview Park Dr Date signed 1/23/48

VS 150

C59353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. C59353

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 509 N Luzerne
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 509 N Luzerne
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anna E Beck

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 29th 1867

8. AGE: Years 80 | Months 11 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business at home

FATHER 12. Name Anton Beck

13. Birthplace Germany

MOTHER 14. Maiden Name Mary Wolf

15. Birthplace Germany

16 (a) Informant Mrs Mary Blake

(b) Address 509 N Luzerne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 26. (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem Coty

Location

18 (a) Funeral director Sellers Funeral Home

(b) Address 200 E Orleans St

19 (a) JAN 24 1948 (Date rec'd by registrar) (b) Funeral Director Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1948, at 11 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1947 to Jan 22 1948 and that I last saw her alive on Jan 22 1948.

Immediate cause of death	Duration
Heart failure (Chronic Myocarditis)	Oct 25/47
Cardio-Vascular-renal disease —	
Due to arterio-sclerosis —	
Due to	
Other Conditions Mitral insufficiency — attend by pulmonary edema	

(Include pregnancy within 3 months of death)

Date of operation July 1936

Major findings of operation: Rt. Kidney removed - Hypernephroma

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis J. Krumrein M.D.

Address 752 N. Kenwood Ave Date signed 1/23/48

VS 150

X

G59354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13/a

Registered No. G59354

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3504 E Lombard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3504 E Lombard
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Fornoff

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife William Fornoff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 27 18

8. AGE: Years	Months	Days	If less than one day
64	-	27	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Louis Le Litte
13. Birthplace Balto.

MOTHER
14. Maiden Name Mary Miller
15. Birthplace Balto

16 (a) Informant Mrs Agnes Button
(b) Address 3504 E Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 26 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Catonsville

18 (a) Funeral director Leibrit Funeral Home
(b) Address 200 S Arlington Ave

19 (a) JAN 24 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1948, at 12 18 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to Jan 1948 and that I last saw her alive on Jan 22 1948

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Hypertension	
Due to Pyelonephritis Cardio renal disease	
Other Conditions Pos Neoplastic disease	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles L MacMunn M. D.
Address 2911 E Balto St Date signed Jan 23 1948

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

659355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 659355

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1607 N. Wolfe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 N. Wolfe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Hansge

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 7th 1875

8. AGE: Years	Months	Days	If less than one day
73	-	14	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Wm Hansge
13. Birthplace Germany

MOTHER
14. Maiden Name Emilie Brandt
15. Birthplace Germany

16 (a) Informant Mrs Louise Hansge
(b) Address 1607 N. Wolfe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 24 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St.

19 JAN 24 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1948, at 11 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1948 to Jan 21 1948 and that I last saw her alive on Jan 20 1948

Immediate cause of death	Duration
Cerebral Hemorage	1/20/48
Due to Chr. myocarditis	1946
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul E. Brown M. D.
Address 1663 W. North Ave. Date signed 1/22/48

VS 150

X

VAIDEN

G59356 BALTIMORE CITY HEALTH DEPARTMENT G59356

CERTIFICATE OF DEATH

937 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3120 St. Paul apt. 302A (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Mr. George Albert Vaiden
3 (b) If veteran, name war — 3 (c) Social Security Account No. —
4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. divorced
6 (b) Name of husband or wife Mrs. M. Belle
6 (c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) Jan 22, 1886
8. AGE: Years 60 | Months 0 | Days 1 | If less than one day ... hr. ... min.
9. Birthplace Gordonsville, Va. (Town, county and state)
10. Usual Occupation School Teacher
11. Industry or business Baltimore, City

MOTHER / FATHER
12. Name Geo. Vaiden
13. Birthplace New Kent Co., Va.
14. Maiden Name Mary Lipscomb
15. Birthplace King & Queen Co., Va.

16 (a) Informant Mrs. John D. Munchs
(b) Address Garden Apts.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/24/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ xx Forest Lawn Cem.
Location Norfolk, Va.

18 (a) Funeral director Wm. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves., Balto., Md.
(c) Filed JAN 24 1948 (Date received by registrar) Clinton for Williams (Registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/23/48 19 , at 1 30 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 1/5/48 19 to 1/23/48 19 , and that I last saw h[illegible] alive on 1/23/48 19 .

Immediate cause of death Coronary occlusion — Duration
Due to arteriosclerotic heart disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph D'Antonio
Address Church Home & Hosp. Date signed 1/29/48

G59357 B of C 31133

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 64

Registered No. G-59357

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1300 Shellbank Road.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1300 Shellbank Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LEONARD BASKERVILLE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 26, 1945

8. AGE: Years 2 | Months 6 | Days 26 | If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Russell Baskerville
13. Birthplace Richmond Va.

MOTHER 14. Maiden Name Veronica Powell
15. Birthplace Boston Va.

16 (a) Informant Russell Baskerville
(b) Address 1300 Shellbank Road

17 (a) Burial (b) Date thereof Jan 24 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) JAN 24 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21, 1948, at 11.45 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Edema of brain.
Status thymicolymphaticus.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 1-22-48

VS 181

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied.

C59358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C59358

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2335 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2335 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jefferson Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Sarah Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1874

8. AGE: Years	Months	Days	If less than one day
73	6	5	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Butler
11. Industry or business

FATHER
12. Name Jefferson Smith
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace Va.

16 (a) Informant Mrs. Sarah Smith
(b) Address 2335 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St. Funeral Director

19 (a) JAN 24 1948 (Registered by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 1948, at 6P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-15-47 19..., to 1-21-48 19..., and that I last saw h[illegible] alive on 1-21-48 19...

Immediate cause of death	Duration
Cardiac Failure	
Due to Cerebral Embolism -	3 days
Due to Hypertension & arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Thos. E. Hamm M. D.
Address 2340 Madison Ave Date signed 1-23-48

V S 130

C59359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. C59359

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore Dundalk
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. Dt. 3 Box 283
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Ranson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-29-03

8. AGE: Years 44 | Months 1 | Days 23 | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Richard Beverly
13. Birthplace Va.

MOTHER
14. Maiden Name Etta Rouzie
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 25-1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Cem.
Location Balto. Md.

18 (a) Funeral director Chas O. Wilson
(b) Address 1020 Bentley ave.

19 (a) JAN 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22 1948, at 9 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 14 1948 to Jan 22 1948, and that I last saw her alive on Jan 22 1948.

Immediate cause of death Nephritis — Duration

Due to

Due to

Other Conditions Diabetes mellitus.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wendell G. Lowrie

Address Johns Hopkins Hosp. Date signed 1-24-48

VS 150

132 1944

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59360

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G59360
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3919 Fait Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3919 Fait Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country — — —

3 (a) FULL NAME Annie Heinlein

3 (b) If veteran, name war — — —

3 (c) Social Security Account No. — — —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John Heinlein
(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1871

8. AGE: Years 77 | Months 0 | Days 10 | If less than one day — hr. — min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name Michael Burger
13. Birthplace Germany

MOTHER
14. Maiden Name Kunigunda Schietz
15 Birthplace Germany

16 (a) Informant Grace Matteson
(b) Address 3919 Fait Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Libly & Zeiler, Inc.
(b) Address 403 S. Wolfe St.

19 (a) JAN 24 1948 (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23 1948 at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 23 1947 to Jan 23 1948 and that I last saw h. alive on Jan 22 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage Nov 23	1948
Arteriosclerosis	1937
Due to Myocarditis	1937
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward J. McElman M. D.
Address 3426 Bank l Date signed Jan 24 48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G59361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G59361

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert
(c) Hospital or institution: Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3906 Canterbury Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Gandy~~ Caudy Elizabeth A Zimmerman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	D

6 (b) Name of husband or wife Edgar R Zimmerman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 29, 1874

8. AGE: Years	Months	Days	If less than one day
73	6	23	hr. min.

9. Birthplace W. Va
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name ~~Fisher Gandy~~ Heishell (Caudy)
13. Birthplace ~~Va~~ Va

MOTHER
14. Maiden Name Henrietta Seymour
15. Birthplace W. Va

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (b) Date thereof 1/26/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Indian Mound
Location Romney, W. Va.

18 (a) Funeral director John C. Mitchell & Sons
(b) Address 1900 Eutaw Place

1948 JAN 24 (Date received by Registrar) Huntington for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-23-48 19 at 11:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-22 1948 to 1-23 1948
and that I last saw h[illegible] alive on 1-23 1948

Immediate cause of death Cerebral Coma — Duration 36 hrs
Due to Diabetes mellitus
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature George R Thomas
Address Union Memorial Hospital Date signed 1-25-48 M.D.

VS 150

G59362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G59362

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Joyce Hotel--314 W. Camden Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GEORGE HUBBARD

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 217-07-6098

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Minnie Hubbard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/23/1873

8. AGE: Years	Months	Days	If less than one day
74	7	29	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Mail Clerk

11. Industry or business

FATHER 12. Name ? Hubbard

FATHER 13. Birthplace Baltimore Co., Md

MOTHER 14. Maiden Name Unknown

MOTHER 15. Birthplace Baltimore Co., Md.

16 (a) Informant Edward Hubbard (Son)

(b) Address 3702 Hudson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1- 26- 48 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem.

Location 7225 Eastern Ave.

18 (a) Funeral director Charles S. Zeiler.

(b) Address 901 S. Conkling St.

19 (a) JAN 24 1948 (Date rec'd by registrar) (b) [illegible] for Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH January 22 1948, at 5:40 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Per: WILLIAM G. HELFRICH, M.D. M.D. Medical Examiner.

Date signed 1- 29-48

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

059363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 059363

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Takoma Park (If outside city or town limits, write RURAL and give town)
(d) Street No. 407 Carroll Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Ralph Edwin Tarbett

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Clara Lawrence Tarbett
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr) Dec. 3, 1882

8. AGE: Years	Months	Days	If less than one day
65	1	20	hr. min.

9. Birthplace Stoneham, Mass. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name William Tarbett
13. Birthplace Boston, Mass.

MOTHER
14. Maiden Name Minnie Bacter
15 Birthplace N.H.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27-48 (month) (day) (year)
(c) Cemetery or crematory Arlington Nat Cem. Location Arlington Va.

18 (a) Funeral director Warren Pumphrey
(b) Address Silver Spring, Md.

19 (a) JAN 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23 1948, at 6:35PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 16 1948, to Jan. 23 1948, and that I last saw h im alive on Jan. 23 1948.

Immediate cause of death	Duration
Rupture of left ventricle cardiac tamponade	Unknown
Due to acute myocardial infarction	10 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 1/24/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. Every item of

G59364

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G59364
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 816 E. NORTH AVE
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 62 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 816 E. NORTH AVE.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Edward Scales.

3 (b) If veteran, name war: No

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) (UNK) 1886

8. AGE: Years	Months	Days	If less than one day
62	—	—	hr. min.

9. Birthplace BALTIMORE (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name JOSEPH E. SCALES
13. Birthplace BALTIMORE

MOTHER
14. Maiden Name MINNIE E. SMITH
15. Birthplace BALTIMORE

16 (a) Informant MAY S. ARTHER
(b) Address 816 E. NORTH AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 26 1948 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location EDMONDSON AVE—CITY.

18 (a) Funeral director Walter Dunby Bradley
(b) Address 1922 W. North Ave.

19 (a) (Date received by registrar) (b) Registrar

JAN 28 1948
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/23/1948, at 4:46 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/20/1948, to 1/23/1948, and that I last saw h[im] alive on 1/22/1948.

Immediate cause of death	Duration
Myocardial Infarction	3 days
Due to Hx. Myocardiolysis	6 mo.
Due to	
Other Conditions Arterial Sclerosis	8 days

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. Mullin M.D.
Address 532 Edmondson Ave Date signed 1/25/1948

Huntington Williams, M.D.

X

C59365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

C59365 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hosp. Women MC
(d) Length of stay in hospital or inst. (yrs., mos., or days) 46 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 21 S. Ann St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Vogelhut

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	Married

6 (b) Name of husband or wife Leon Vogelhut
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-15-'87

8. AGE: Years	Months	Days	If less than one day
60	6	9	hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Martin Graber
13. Birthplace Austria

MOTHER
14. Maiden Name Nettie Lindenberg
15. Birthplace Austria

16 (a) Informant Milton Vogelhut
(b) Address 21 S Ann St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 25, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Philadelphia Road Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Registered by registrar) (b) Huntington Williams, M.D. Registrar

1 25 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 24 - 1948, at 10 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1947, to Jan 24 1948, and that I last saw h[illegible] alive on Jan 24 1948.

Immediate cause of death	Duration
Pulm. Oedema	
Due to Cardiac Decompensation	
Due to Coronary Sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Coronary Sclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George H. Goldenberg M.D.
Address W. N. Y. Date signed 1-29-48

X

G59366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G59366

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3506 Glen Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3506 Glen Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Warshaw

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Israel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business House Wife

FATHER
12. Name Julius Lipnick
13. Birthplace Russia

MOTHER
14. Maiden Name Glichia Kurland
15. Birthplace Russia

16 (a) Informant Kadish Lipnick
(b) Address 1642 Ruxton Ave

17 (a) Burial (b) Date thereof Jan 25, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sharrei Tfiloh Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) JAN 25 1948 (b) Interment Williamsport, Md.
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION 8.10

20. DATE OF DEATH January 23 1948, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1945 to Jan 1948.
and that I last saw h[illegible] alive on 1/23 1948.

Immediate cause of death pulmonary edema

Due to Coronary artery disease

Due to

Other Conditions Diabetes, Arterial hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Dennis Wilson M. D.

Address 5721 Park Heights Ave Date signed 1/24/48

94a

G59367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓94a

G59367 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2119 Presbury St
(c) Hospital or institution: 13th
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2424 Lakeview Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis Schwartz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Late Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 83 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Max Schwartz
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael ?
15. Birthplace Russia

16 (a) Informant Henry Schwartz
(b) Address 2424 Lakeview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan, 25, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) JAN 25 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23 1948, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1 1948 to 1/23 1948, and that I last saw h[illegible] alive on 1/23 1948.

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Chodcoff M. D.
Address 2225 Linden Ave Date signed 1/24/48

V S 150

G59368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 557

G59368 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 374 Mt. Olivet Lane
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 374 Mt. Olivet Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Orsola P. De Mario

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband wife of the late Antonio
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30 1880

8. AGE: Years	Months	Days	If less than one day
67	3	23	hr. min.

9. Birthplace Picciano Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Raffaele Di Silverio
13. Birthplace Italy

MOTHER
14. Maiden Name Filomena Di Gianbattista
15. Birthplace Italy

16 (a) Informant Louis De Mario (Son)
(b) Address 374 Mt. Olivet Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 26/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 25 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1948, at 8.45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946 to Jan 22 1948, and that I last saw h. Pt alive on Jan 19 1948.

Immediate cause of death: Carcinoma of gall bladder

Due to Carcinomatosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1 yr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. M. Callen M. D.
Address 3321 Frederick Rd. Date signed 1/25/48

Testator for Williams, M.D.

X. 1/25/48

G59369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

G59369 Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3013 Ferndale Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3013 Ferndale Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Dora Elizabeth Boyle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Harry F. Boyle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 21 1872

8. AGE: Years	Months	Days	If less than one day
75	10	2	hr. min.

9. Birthplace Glouster Co. Va.

(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER 12. Name John W. Smith

13. Birthplace Dorchester Co Md

MOTHER 14. Maiden Name Alice Anna Rowe

15. Birthplace Glouster Co. Va.

16 (a) Informant Harry W. Boyle

(b) Address 3013 Ferndale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 26 1948 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Woodlawn Md

18 (a) Funeral director Harry F. Linnacost

(b) Address 4204 Ridgewood Ave

JAN 25 1948 (Date rec'd by registrar) (b) Livingston Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jany 23 1948 at 10 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Jan 23 1948 and that I last saw h alive on Jan 23 1948.

Immediate cause of death Cerebral Vase Accident — Duration 2 hr

Due to Hypertension Cardio Vas Disease — 3 yrs

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Thos J Abbott M. D.

Address 4509 Liberty Heights Date signed 1-24-48

VS 150

G59370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G59370

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1804 Aiken Street
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (9)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 Aiken Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: Catherine S.Metz

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Francis X.Metz

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) March 1st.,1858

8. AGE: Years 89 | Months 10 | Days 22 | If less than one day ######### min.

9. Birthplace Baltimore,Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Samuel G.Davidson
13. Birthplace Baltimore,Md.

MOTHER
14. Maiden Name Mary J.Powell
15. Birthplace Baltimore,Md.

16 (a) Informant Mrs.Mary J.Romans (Niece)
(b) Address 1316 E.Lafayette Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof I/27/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road,Balto:Md.

18 (a) Funeral director George J.Ruth,Inc.
(b) Address 1735 Harford Avenue

19 (a) _____ (Date rec'd by registrar) (b) [illegible] Registrar

JAN 25 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23rd 1948, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1943 to Jan 23 1948 and that I last saw h[illegible] alive on Jan 23 1948.

Immediate cause of death: Coronary Thrombosis — Duration 1/22/48

Due to Ch. Myocarditis — 1/1/43

Due to Arterio Sclerosis Generalized — 1/1938

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Roane M.D.

Address 801 N Carrollton Ave Date signed 1/23/48

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G59371
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3732 Old York Rd
(c) Hospital or institution:
9+1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3732 Old York Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes S. Read

3 (b) If veteran, name war
3 (c) Social Security Account No. 215-16-6721

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Married

6 (b) Name of husband or wife Charles R. Read
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 31, 1912

8. AGE: Years	Months	Days	If less than one day
35	2	23	hr. min.

9. Birthplace New Jersey (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Clarence C. Libby
13. Birthplace

MOTHER
14. Maiden Name Nannie M. Markoe
15. Birthplace

16 (a) Informant Charles R. Read
(b) Address 3732 Old York Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director John A. Morgan
(b) Address 3000 E. Balt. St.

19 (a) (Date received by registrar) (b) Huntington Williams
JAN 25 1948
VS 10)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23, 1948, at 8 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 31 1919, to 1-23 1948, and that I last saw her alive on 1-21 1948.

Immediate cause of death	Duration
Mesenteric Thrombosis	24 hours
Due to General Carcinomatosis	?
Due to Carcinoma of cervix & body of uterus	4/22/47
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 6/20/47
Major findings of operation: Carcinoma of cervix
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Anthony J. Thomas M. D.
Address 4600 York Rd Date signed 1/24/48

X

G59372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 55E

G59372 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2468 Greenmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Schabb

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Anna
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) 1877

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Shoe Maker
11. Industry or business

FATHER
12. Name Isaac
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Mrs Gertrude Cohen
(b) Address 4005 Pinkney Road
17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1-25-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Hebrew Cem
Location
18 (a) Funeral director Jack Lewis Inc
(b) Address 2400 Eastern Place
19 (a) JAN 25 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-23-48 1948 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-23-48 1948 to 1-23 1948 and that I last saw him alive on 1-23 1948.

Immediate cause of death	Duration
Cardiac decompensation	
Due to Metastatic carcinoma of lung	
Due to Carcinoma, primary site unknown	
Other Conditions Arteriosclerotic C-V Disease (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bernard S Cohen M. D.
Address Sinai Hosp, Balto, Md Date signed 1-23-48
X Cohen

VS 150

G59373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G59373 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St

(c) Hospital or institution: Sinai Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 11

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Pikesville Home For Aged (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Esther R Scheuberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years	Months	Days	If less than one day
86			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Alexander

13. Birthplace Poland

MOTHER 14. Maiden Name Lazh

15. Birthplace Poland

16 (a) Informant Benjamin Scheuberg

(b) Address 7119 Laurel Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-48 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Philadelphia Rd Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 2166 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

JAN 26 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/24/ 1948, at 4 — AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/11/48 19 to 1/24/ 1948, and that I last saw h alive on 1/24 19 48

Immediate cause of death Coronary insufficiency

Due to Arterio-Sclerotic C-V Disease

Due to

Other Conditions Carcinoma of sigmoid (Include pregnancy within 3 months of death)

Date of operation 1/16/48

Major findings of operation: Mass in Sigmoid

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Irving Cohen

Address Sinai Hosp Date signed 1/24/48 M.D.

X

G59374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1084

G59374

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1407 Madison Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lillie Branford Hill Hawkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Colored | 6 (a) Single, married, widowed or divorced: Divorced

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1916

8. AGE: Years 31 32 | Months 4 | Days 4 | If less than one day hr. min.

9. Birthplace Anne Arundel Co. Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Mathias Branford
13. Birthplace Anne Arundel Co. Md.

MOTHER
14. Maiden Name Sophie Queen
15. Birthplace Anne Arundel Co. Md.

16 (a) Informant Mrs. Sophie Boardley
(b) Address 1407 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 27 1948 (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Mt. Lebanon Md

18 (a) Funeral director Mrs. Lucy A. Stallard
(b) Address 31 Druid Hill Ave

JAN 25 1948

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23 1948, at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15 1948, to 1-23 1948, and that I last saw h[illegible] alive on 1-23 1948.

Immediate cause of death: Right Lobar Pneumonia — Duration: 8 days

Due to —

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Franklin Phillips M. D.
Address 1543 Penna. Ave Date signed 1/26/48

VS 150

Please write plainly in BLACK or BLUE INK, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59375 BALTIMORE CITY HEALTH DEPARTMENT G59375 Registered No.

CERTIFICATE OF DEATH 194a

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1870 Druid Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1870 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Albert L. James

3 (b) If veteran, name war

3 (c) Social Security Account No. 709-12-4590

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Beatrice B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1896

8. AGE: Years 51 | Months 3 | Days - | If less than one day hr. min.

9. Birthplace Florence, S. C. (Town, county, and state)

10. Usual Occupation Pullman porter

11. Industry or business

FATHER 12. Name Robert James

13. Birthplace Sumpter, S. C.

MOTHER 14. Maiden Name Ella Robinson

15. Birthplace Florence, S. C.

16 (a) Informant Mrs. Beatrice B. James

(b) Address 1870 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 25, 1948 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk.

Location Baltimore Co. Md.

18 (a) Funeral director Chas. Law A. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) Jan 25 1948 (Date rec'd by registrar) (b) Livingston Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1948, at 3:30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 1948 to Jan 22 1948 and that I last saw him alive on Jan 22 1948.

	Duration
Immediate cause of death: Coronary Thrombosis	
Due to: Hypertension	1 yr
Due to: Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ned H. Roberts M. D.

Address 1723 Druid Hill Ave. (Date signed)

VS 150

1-24-48

G59376

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G59376 Registered No. 93c

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2550 W. Fayette St.
(c) Hospital or institution: 20-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2550 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Annette Orrell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Richard B. Orrell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1907

8. AGE: Years	Months	Days	If less than one day
41	0	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation House-wife
11. Industry or business

FATHER
12. Name William C. White
13. Birthplace Port Deposit, Md.

MOTHER
14. Maiden Name Catherine M. Massey
15. Birthplace Baltimore, Md.

16 (a) Informant Richard B. Orrell
(b) Address 2550 W. Fayette St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

19 JAN 25 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION 6.50

20. DATE OF DEATH January 23, 1948 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/29, 1947 to 1/23 1948. and that I last saw h[illegible] alive on 1/22, 1948.

Immediate cause of death Chronic myocarditis and myocardial degeneration, rheumatic — Duration 3 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gilbert E. Rudman M. D.
Address 2517 W. Balto. St. Date signed 1/23/48

VS 150

Funeral for Williams, Md.

G59377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48 B

G59377 Registered No.

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1104 S. Streeper st
(c) Hospital or institution: 1-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 S. Streeper (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helena Krolikowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-14-1594

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Joseph Krolikowski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 10 ''

8. AGE: Years 29 | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name John Zych

13. Birthplace Poland

MOTHER 14. Maiden Name Marcyanna Wasiekewska

15. Birthplace Poland

16 (a) Informant Mrs Joseph Krolikowski

(b) Address 1104 S. Streeper st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/26/48 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Dundalk Ave

18 (a) Funeral director Marie E. Trathowski

(b) Address 1000 S Remwood Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. (Signature of registrar)

JAN 25 1948

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1948 at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Jan 22 1948 and that I last saw her alive on Jan 22 1948.

Immediate cause of death Carcinoma of Uterus c General Metastasis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.

Address 529 Eastern av. Date signed

G59378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

G59378 Registered No.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address Southern Hotel (Light + Redwood)
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 wk
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town Young's town (If outside city or town limits, write RURAL and give town)
(d) Street No. 433 Crandall Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Luther W. Reese

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No. 465-05-0872

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Barbara (nee Stechel)

6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) Nov 28, 1918

8. AGE: Years 29 | Months 1 | Days 26 | If less than one day: hr. min

9. Birthplace Ballinger, Texas (Town, county and state)

10. Usual Occupation Geologist

11. Industry or business Petroleum

FATHER
12. Name James C. Reese
13. Birthplace —

MOTHER
14. Maiden Name Willie Watson
15. Birthplace —

16 (a) Informant Barbara Reese - Wife
(b) Address 433 Crandall Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof JAN. 30, 1948 (month) (day) (year)
(c) Cemetery or crematory Ballinger
Location Ballinger, Texas

18 (a) Funeral director Walter Burke Bradley
(b) Address 1922 W. North Avenue, Baltimore, Md.

19 (a) JAN 26 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/25/48 19 at 12:15 A M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Melanotic Sarcoma, generalized

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner.
Date signed 1/25/48

VS 151

C59379 Wbg H

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. C59378

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT CLEARLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Ruxton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth H. Michell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 21 1877

8. AGE: Years	Months	Days	If less than one day
70	4	4	hr. min.

9. Birthplace Phila Pa (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name James A Henry
13. Birthplace Pa

MOTHER
14. Maiden Name Juliet Howell
15. Birthplace Pa

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1-26-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Philadelphia Pa

18 (a) Funeral director Wm J Lichtenstein Sons
(b) Address N Patterson Ave Balto

19 (a) JAN 26 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-25 1948, at 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-4 1948 to 1-25 1948, and that I last saw her alive on 1-25 1948

Immediate cause of death Pulmonary edema — Duration
Due to Arteriosclerotic heart disease
Due to
Other Conditions Uremia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marvin B. Day M. D.
Address Johns Hopkins Hosp Date signed 1-26-48

VS 150

Marvin B. Day

G59380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G59380 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Hanover
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town New Windsor R 1
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Percy W Babylon

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Sarah Louise Babylon
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) June 16 1886

8. AGE: Years	Months	Days	If less than one day
61	7	10	hr. 1 min.

9. Birthplace Carroll County Md.
(Town, county and state)
10. Usual Occupation Vault Mfg.
11. Industry or business Concrete Vaults

FATHER
12. Name J. Fletcher Babylon
13. Birthplace Md.

MOTHER
14. Maiden Name Jennetta Hoover
15. Birthplace Md

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (b) Date thereof Jan 28 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pine Creek Cem.
Location Near New Windsor, Md

18 (a) Funeral director J. Francis Reese
(b) Address Westminster, Md

19 (a) JAN 26 1948 (Date received by registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 1948 at 12:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-24 1947 to 1-26 1948 and that I last saw h[illegible] alive on 1-25 1948.

Immediate cause of death Coronary Occlusion — Duration

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A Nightower M. D.
Address University Hosp. Date signed 1-26-48

VS 150

C59381

CLEMENNS

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 164c

Registered No. C59381

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Cabot St.
(c) Hospital or institution: Mercy Hospital 11-V
(d) Length of stay in hospital or inst. (yrs., mos., or days): D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 34 E. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: WILLIAM W. CLEMENTS

3 (b) If veteran, name war: ✓

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	M

6 (b) Name of husband or wife:

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1912

8. AGE: Years	Months	Days	If less than one day
36			hr. min.

9. Birthplace: California
(Town, county, and state)

10. Usual Occupation: Chief Eng. Mchnt. Marines

11. Industry or business:

FATHER
12. Name: ✓
13. Birthplace: ✓

MOTHER
14. Maiden Name: ✓
15. Birthplace: ✓

16 (a) Informant: Clifford N. Huffman
(b) Address: 3416 E. Pratt St.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof:** Jan 16-48 (month) (day) (year)
(c) Cemetery or crematory: Western Cemetery
Location: Balto.

18 (a) Funeral director: Pearce A. Nusbaum
(b) Address: Reisterstown Md.

19 (a) JAN 26 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14, 1948, at 12.10a M

21. I certify that I took charge of the remains described above, held an insp.& inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Gunshot wound Heart.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-13-48 at 11.30 p. M.
(b) Where did injury occur? 34 E. Preston St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury: Firearms.

23. Signature: Carl L. Ryer M.D.
Medical Examiner.
Date signed 1-14-48

X

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any item of information should be carefully supplied.

G59382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G59382

Physicians: please write the causes of death clearly and legibly. The ... especially important. ... supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 130 N. Milton Ave.
(c) Hospital or institution: 6-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 130 N. Milton Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Gilbert Martin

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary (nee Rosch) 6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1867

8. AGE: Years	Months	Days	If less than one day
80	11	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county and state)
10. Usual Occupation retired (Transit Co.)
11. Industry or business

FATHER
12. Name James Martin
13. Birthplace Ireland

MOTHER
14. Maiden Name Rose ?
15. Birthplace Maryland

16 (a) Informant Mary Martin.
(b) Address 130 N. Milton Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 1/26/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director The Dyer Brothers
(b) Address 1800 E. Lombard St.

19 JAN 26 1948 Huntington Williams M.D. (Date received by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23 1948, at 5:54 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/17 1948 to 1/23 1948, and that I last saw h[illegible] alive on 1/22 1948.

Immediate cause of death	Duration
Chronic Nephritis	
Chronic Myocarditis	
Due to Arteriosclerosis	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Tawney M. D.
Address 4 [illegible] Ellwood Ave Date signed 1/24/48

VS 150

X

B-00445

G59383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157M

Registered No. G59383

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St. 131
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 6 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore - 17
(If outside city or town limits, write RURAL and give town)
(d) Street No. 917 Channery Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Jacobs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Wht	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/10/48

8. AGE: Years	Months	Days	If less than one day
NB —	—	—	6 hrs. min.

9. Birthplace Balto. - Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Sol R. Jacobs
13. Birthplace N.Y.C. - N.Y.

MOTHER
14. Maiden Name Lillian Toback
15. Birthplace N.Y.C. - N.Y.

16 (a) Informant Father Sol R. Jacobs
(b) Address 917 Channery Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 22 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11, 1948 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1948 to 1/11 1948 and that I last saw her alive on 1/11 1948

Immediate cause of death: Multiple congenital abnormalities — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irwin H. Kaiser M. D.
Address Sinai Hospital Date signed Jan 21

VS 3

X

G59384

BC-48-00057

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

G59384 Registered No.

Physicians: please write the causes of death clearly and legibly. The correct age is especially important. Information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1dy
(e) Length of stay in Baltimore (yrs., mos., or days) 1dy

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto - 14 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1603 Orlando Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Bagwell
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male
5. Color or race W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1/2/48
8. AGE: Years NB. Months Days 1 If less than one day hr. min.
9. Birthplace Balto - Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Chas. K. Bagwell
13. Birthplace Balto - Md.

MOTHER
14. Maiden Name Mgt. Tennant.
15. Birthplace

16 (a) Informant Margaret E. Bagwell
(b) Address 1603 Orlando Rd.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Loc Johns Hopkins Medical School JAN 22 1948
Commissioner of Health

18 (a) Funeral director
(b) Address Huntingtown Williams, MD

19 JAN 26 1948 (Date filed by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/3 1948, at 6:45 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 1/2 1948 to 1/3 1948 and that I last saw him alive on 1/3 1948.

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: PREMATURITY

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Sussman M. D.
Address Sinai Hospital Date signed 1/4/48

VS 150

359385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G59385

Registered No.

BC-G 16501

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address E. Monument St

(c) Hospital or institution: Sinai Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Balto - 21 (If outside city or town limits, write RURAL and give town)

(d) Street No. 218 Edgewater Apts (If rural give location)

(e) Citizen of foreign country (Yes or No) If yes, name country

3 (a) FULL NAME George John Duvall, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17-1947

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace Balto - Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Geo - John Duvall

13. Birthplace Balto - Md.

MOTHER — 14. Maiden Name Shirley F. Croop

15. Birthplace Scranton - Pa

16 (a) Informant Shirley F. Duvall

(b) Address 218 Edgewater apts 21

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Johns Hopkins Medical School

Location JAN 22 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) JAN 26 1948 (Date rec'd by registrar) (Signature) for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17, 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 17 1947 to Dec. 17, 1947 and that I last saw him alive on Dec. 17, 1947

Immediate cause of death Prematurity — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Sydney Lurie M. D.

Address Sinai Hosp Date signed

VS 3

Form H 2

HEALTH DEPARTMENT—CITY OF BALTIMORE

G59386 Died: 1-22-48 BC: 48-01498

CERTIFICATE OF DEATH √159

G59386

Registered No.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Volunteers of America Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME ~~Forbes~~ MARY ROBERTA SHOCK

If U. S. Veteran specify WAR

(a) Residence: No. 4716 Ivanhoe Ave St., Ward. 27-10

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) Jan. 22, 1948

7. AGE	Years	Months	Days	If LESS than 1 day, 3 hrs. or 10 min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. —

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto Md

FATHER

13. NAME Joseph Shock

14. BIRTHPLACE (city or town) (State or country) Riderwood Md

MOTHER

15. MAIDEN NAME Mary Rose

16. BIRTHPLACE (city or town) (State or country) Balto Md

17. INFORMANT Mary Shock

(Address) 4716 Ivanhoe Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Date 19

19. UNDERTAKER Johns Hopkins Medical School JAN 23 1948

(Address) Commissioner of Health

20. FILED JAN 26 1948 19 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Jan. 22, 1948

22. I HEREBY CERTIFY, That I attended deceased from Jan 22, 1948, to Jan 22, 1948

I last saw her alive on Jan. 21 1948. Death is said to have occurred on the date stated above, at 6 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Respiratory failure	1/22/48
Other contributory causes of importance: Prematurity - Wt 1½ lb.	

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) Howard Taylor, M. D.

(Address) Volunteers of America Hosp.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V0 8

X

G59387

HEALTH DEPARTMENT—CITY OF BALTIMORE

Twin #1

CERTIFICATE OF DEATH ✓ 159

G59387

1. PLACE OF DEATH 3C-43-0,497

CITY OF BALTIMORE: (No. Volunteers of America Hospital Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME FRANCES EILEEN SHOCK

If U. S. Veteran specify WAR.

(a) Residence: No. 4716 Dunkirk Ave St., Ward. 27-10

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) Jan 22, 1948

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
			3 hrs.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. —

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto Md

FATHER

13. NAME James Shock

14. BIRTHPLACE (city or town) (State or country) Redinwood, Md

MOTHER

15. MAIDEN NAME Mary Rose

16. BIRTHPLACE (city or town) (State or country) Balto Md

17. INFORMANT Mary Shock

(Address) 4716 Dunkirk Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Date 19

19. UNDERTAKER Johns Hopkins Medical School JAN 23 1948

(Address) Commissioner of Health

20. FILED JAN 26 1948 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Jan 22, 1948

22. I HEREBY CERTIFY, That I attended deceased from Jan 22, 1948 to Jan 22, 1948

I last saw h alive on Jan 22 1948 Death is said to have occurred on the date stated above, at 6:30 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Respiratory failure	Jan/48
Other contributory causes of importance: Prematurity - Wt 1 1/4 lb.	

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Richard Lott M. D.

(Address) Volunteers of America Hosp.

X

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G59388 BC = 48-002 Stillbirth 159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59388

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 Homewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Thompson "A"

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-6-48

8. AGE: Years | Months | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Lillian Thompson

15. Birthplace Va.

16 (a) Informant JOHNS HOPKINS HOSPITAL

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Location Johns Hopkins Medical School JAN 21 1948 Commissioner of Health

18 (a) Funeral director

(b) Address

19 (a) JAN 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1948 at 2 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 6 1948 to Jan 12 1948, and that I last saw him alive on Jan 12 1948.

Immediate cause of death PREMATURITY WITH ATELECTASIS. — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry M. Seidel M. D.

Address Johns Hopkins Hosp Date signed 1/12/48

VS 150

X

CORRECT AGE IS ESPECIALLY IMPORTANT. PHYSICIANS: PLEASE WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY. WITH UNFADING INK. Every item of information should be carefully supplied.

G59389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 46 B

Registered No. G59389

The correct age is especially important. Physicians; please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 7-5
(d) Length of stay in hospital or inst. (yrs., mos., or days): 86 days
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 709 N. Broadway (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Alexander Selkirk Gage (ALEXANDER SEILKIRK GAGE)

3 (b) If veteran, name war: No --
3 (c) Social Security Account No.: NONE --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife: Ida E. Gage
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 5, 1868

8. AGE: Years	Months	Days	If less than one day
79	5	18	hr. min.

9. Birthplace: Balto, Md. (Town, county, and state)
10. Usual Occupation: Physician
11. Industry or business:

FATHER
12. Name: Wm. L. Gage
13. Birthplace: Md.

MOTHER
14. Maiden Name: Hannah Dorsey
15. Birthplace: Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1/26/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC
(b) Address: NORTH AVE. & BROADWAY

19 (a) JAN 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 23 1948, at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 29 1947 to Jan. 23 1948, and that I last saw him alive on Jan. 23 1948.

Immediate cause of death: Carcinoma of stomach with extension to pancreas and regional lymph nodes and with metastases to liver — Duration: 1½ yrs.

~~Due to~~

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed: 1/23/48

VS 150

X

G59390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G59390

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3044 O'Donnell St
(c) Hospital or institution: 1-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3044 O'Donnell St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM NORRIS HURTT SR.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	216-24-7005

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Wilhelmina Franke
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr) Mar. 8. 1880

8. AGE: Years	Months	Days	If less than one day
67	10	15	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Policeman
11. Industry or business Retired 4 years

FATHER
12. Name Morgan Hurtt
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Spangler
15. Birthplace Maryland

16 (a) Informant Mrs. Wilhelmina F. Hurtt
(b) Address 3044 O'Donnell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 28 1948 (month) (day) (year)
(c) Cemetery or crematory Trinity Cem.
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address Baltimore 13 Md.

19 (a) JAN 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23. 1948 at 11.30A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1947, to Jan. 23 1948, and that I last saw him alive on Jan. 23 1948.

Immediate cause of death	Duration
Coronary Thrombosis	30 min.
Due to	
Due to	
Other Conditions Diabetes Mellitus, Chronic Hypertension	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 3048 O'Donnell St. Date signed 1-24-48

VS 150

94a

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WITH UNFADING INK.

G59391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 49a

Register G59391

The information should be carefully supplied. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard & Madison Ave.
(c) Hospital or institution:
Maryland General Hospital 763
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3400 6 Lieftmont Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Evelyn M Button (EVELYN MAUD BUTTON)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	M.

6 (b) Name of husband ~~or wife~~ William Button
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) 26 Nov. 1907

8. AGE: Years	Months	Days	If less than one day
40	1	27	— hr. — min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Charles W. Knight
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Evelyn M. Maguire
15. Birthplace Baltimore, Md.

16 (a) Informant William E. Button
(b) Address 3420 Cliftmont Avenue-13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) JAN 26 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Jan. 1948, at 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 23 Jan. 1948 to 23 Jan. 1948 and that I last saw h[illegible] alive on 23 Jan 1948.

Immediate cause of death	Duration
(a) Cardio respiratory failure	
(b) Sepsis Uterii	
Due to (c) Intestinal obstruction	
(d) Carcinoma (generalized abdominal viscera)	over
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none Date
Major findings of operation: —
of autopsy: none Date

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature W. K. Brendle M. D.
Address 9 W. Dew. Hosp. Date signed 23 Jan '48

VS 150

G59392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G59392

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place 263
(c) Hospital or institution: Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3709 Belair Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD ALBERT GLASER

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 217-09-1048

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Widowed

6 (b) Name of husband or wife Elizabeth Glaser
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) Jan. 11. 1876

8. AGE: Years	Months	Days	If less than one day
72	1 0	12	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Insurance
11. Industry or business Retired 12 years

FATHER
12. Name Edward A. G. Glaser
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Popp
15. Birthplace Germany

16 (a) Informant Mrs. Eva Meyer
(b) Address 3321 Kenyon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 23. 1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address Baltimore Md.

19 (a) JAN 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23. 1948 19 , at 7.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug - 1946 to Jan 23 1948
and that I last saw h alive on 19

Immediate cause of death: Coronary Thrombosis
Due to Arteriosclerosis
Due to Cardio-Vascular Disease
Other Conditions

Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) (While at work?)
(e) Means of injury

23. Signature H. H. Leverett, M.D.
Address 3400 Edward Ave Date signed 1/24/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

G59393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 131a

G59393 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: Lo Balto Gen Hospital 24-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1256 Riverside Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES P HOWARD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Georgia Howard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-6-(89) 1888

8. AGE: Years	Months	Days	If less than one day
59	1	16	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Maintenance Foreman-City Rec

FATHER 12. Name Charles Howard
13. Birthplace Md. (England)

MOTHER 14. Maiden Name Smith
15. Birthplace Md.

16 (a) Informant Wife
(b) Address Same

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 1/25/48 (month) (day) (year)
(c) Cemetery or crematory Ft Lincoln
Location Ft Lincoln Cemetery

18 (a) Funeral director D. E. Lee Carney
(b) Address 1820 S. Fay St. Balto

19 JAN 26 1948 (Date rec'd by registrar) (Signature) for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-22-1948 at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-17-1948 to 1-22-1948 and that I last saw him alive on 1-22-1948

Immediate cause of death Acute myocardial failure — Duration

Due to Myocardial infarction — 6 days

Due to Coronary atherosclerosis + Hypertensive C-V disease

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same + Clinical

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Sinai Balto Md Date signed 1-26-48

VS 150

937

G59394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered G59394

82a

Type or print in PERMANENT BLACK INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 400 Whitridge Ave.
(c) Hospital or institution: 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 400 Whitridge Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter F. Knight

3 (b) If veteran, name war: No.

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Mary Gunning Knight

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) May 10. (1894)

8. AGE: Years	Months	Days	If less than one day
(54) 54	8	13	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Gardener

11. Industry or business John Hopkins University

FATHER
12. Name August Knight
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Mary Knight
(b) Address 400 Whitridge Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 27, 1948 (month) (day) (year)

(c) Cemetery or crematory Mount Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Edgar W. Conklin's Son
(b) Address 924 E. Eager St.

19 JAN 26 1948 (Date rec'd by registrar) (b) Lattimore Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23, 1948, at 7a M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 8 1947 to Jan 23 1948, and that I last saw him alive on Jan 20 1948.

Immediate cause of death Cerebral Hemorrhage — Duration 11 months

893

Due to Arteriosclerosis — ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Victor Goldberg M.D.
Address 3100 Harford Road Date signed 1/23/48

V S 150

Zone 18

C59395

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. C59395

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1119 West 42nd Street
(c) Hospital or institution: 13-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 West 42nd Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CLARENCE WHITE

3 (b) If veteran, name war	3 (c) Social Security Account No.
I	PC 212-10-9074

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Flora M White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15 - 1895

8. AGE: Years	Months	Days	If less than one day
52	1	9	hr. min.

9. Birthplace Lebanon Ga (Town, county, and state)
10. Usual Occupation clerk
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Flora M White
(b) Address 1119 W 42nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-48 (month) (day) (year)
(c) Cemetery or crematory Woodland Memorial Park
Location Parkville Balto Md

18 (a) Funeral director Frank H Seth
(b) Address 5644 W 36th St.

19 (a) JAN 26 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/24/48 19..., at 1:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D. Medical Examiner.
Date signed 1/24/48

VS 151

Correct age is especially important. Physicians please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G59396
AB- 116859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59396

The information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1403 W. Ostend St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Oscar Pluschkell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16- 1885

8. AGE: Years	Months	Days	If less than one day
62	1	9	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name August (D
13. Birthplace Germany

MOTHER
14. Maiden Name Johanna ? (D
15. Birthplace Germany

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md

18 (a) Funeral director Williams & Lee

(b) Address 1217 Eutaw St.

19 JAN 26 1948 (Date rec'd by registrar) (b) Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25- 1948 at 6.25A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-24- 1948 to 1-25- 1948, and that I last saw him alive on 1-25- 1948.

Immediate cause of death	Duration
Diabetes Mellitus & acidosis and coma	? + 3 days.
Due to	
Due to Generalized arteriosclerosis	
Other Conditions Benign prostatic hypertrophy, Cholelithiasis (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.

Address Baltimore City Hosp Date signed 1-26-48

VS 150

G59397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √137a

G59397 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital 27-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 48 days
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 542 Radnor Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) **FULL NAME** Harry B. Parsons

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Anna Parsons
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) Sept. 12, 1869

8. AGE: Years	Months	Days	If less than one day
78	5 4	11	hr. min.

9. Birthplace Wash. D. C. (Town, county, and state)
10. Usual Occupation Minister
11. Industry or business Retired

FATHER
12. Name James L. Parsons
13. Birthplace Wash. D.C.

MOTHER
14. Maiden Name Mary Ann Brereton
15. Birthplace ? Md.

16 (a) Informant Anna Parsons
(b) Address 542 Radnor Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/48 (month) (day) (year)
(c) Cemetery ~~or cremation~~ Parkwood
Location Parkville Md

18 (a) Funeral director William Cook Inc.
(b) Address 217 St. Paul St. Huntington Williams, Mgr.

19 (a) JAN 26 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23, 1948, at 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-6 1947, to 1-23 1948, and that I last saw him alive on 1-23 1948.

	Duration
Immediate cause of death Hypostatic Pneumonia Acedosis	48 days
Due to Arteriosclerotic Cardiovascular Renal Disease.	?
Due to	
Other Conditions ~~None~~	

(Include pregnancy within 3 months of death)
Date of operation 12-9-47
Major findings of operation: Carcinoma Prostate Hypertrophy - Chronic Prostatitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Joseph Di Pisa M. D.
Address Mercy Hosp. Date signed 1-23-48

VS 150

X

G59398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59398

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Lansdowne (If outside city or town limits, write RURAL and give town)
(d) Street No. 35 Clyde Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Melvin Stevens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22. 1898

8. AGE: Years	Months	Days	If less than one day
49 58	6	2	hr. min.

9. Birthplace Jefferson Co. W Va (Town, county, and state)
10. Usual Occupation Woodworkman
11. Industry or business Lord Mott Packing Co

FATHER
12. Name Phil Singh Stevens
13. Birthplace Va

MOTHER
14. Maiden Name Sadie Johnson
15. Birthplace W Va

16 (a) Informant Mr Charles Stevens
(b) Address 131 Parkin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/48 (month) (day) (year)
(c) Cemetery or crematory Masonic
Location Middletown W Va

18 (a) Funeral director Milton Robbins
(b) Address 1217 E Lombard St

19 (a) JAN 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/24 1948, at 2 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Ruptured Aneurysm
Thoracic Aorta

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L Rogers M.D. Medical Examiner.
Date signed 1/25/48

VS 181

Please write as especially important. Physicians: please write the causes of death clearly and legibly. The

C59399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C59399

The information should be carefully supplied. Every item of information should be carefully supplied, WITH UNFADING INK. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20-4
(c) Hospital or institution West Baltimore Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2452 Frederick Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Myrtle M. BUCHER

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex: Female — 5. Color or race: White — 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lucian G.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 18 1898

8. AGE: Years 49 | Months 3 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Woman Worker

11. Industry or business

FATHER
12. Name Volney von Woodroe
13. Birthplace Md

MOTHER
14. Maiden Name Kate T Cain
15. Birthplace Md

16 (a) Informant Mrs Kate T Kessler
(b) Address 1820 Linwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/48 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Md
Location Baltimore Md

18 (a) Funeral director Williams & Doe
(b) Address 1320 Cont St

19 (a) JAN 26 1948 (Date rec'd by registrar) (b) Courtney for Williams M.D. registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1948; at 1:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 1948, to Jan 25 1948, and that I last saw her alive on Jan 25 1948.

Immediate cause of death	Duration
Cardio respiratory failure	
Due to Cerebral haemorrhage	
Due to Hypertension - essential	
Other Conditions Hypertensive C-V D disease (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Cerebral edema - Arteriosclerosis hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Fuller MD
Address West Baltimore Date signed 1-25-48 M. D.

VS 150

Seal

82a

G59400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G59400 Registered No.

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ days

2. USUAL RESIDENCE OF DECEASED:
(a) State N J (b) County
(c) City or town Budgton (If outside city or town limits, write RURAL and give town)
(d) Street No. 113 Cohansey St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eva Everingham

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife: George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept 8 1890

8. AGE: Years	Months	Days	If less than one day: hr.	min.
57	4	17		

9. Birthplace: Millville N J (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:
FATHER 12. Name: John Simpkins
13. Birthplace: N J
MOTHER 14. Maiden name: Carrie Tolbert
15. Birthplace: N J
16 (a) Informant: Geo. Everingham
(b) Address: Bridgeton N J
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1/27/48 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Salem Co N J
18 (a) Funeral director: Wilson & Son Inc
(b) Address: 127 E Pearl St
19 JAN 26 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 Jan 1948, at 4:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 23 Jan 1948, to 25 Jan 1948, and that I last saw her alive on 25 Jan 1948.

Immediate cause of death	Duration
Diabetic coma	
Due to: Diabetes mellitus	
Due to:	
Other Conditions: Rheumatic heart disease (Include pregnancy within 3 months of death)	

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Laham M. D.
Address Franklin Sq. Hosp Date signed 25 Jan 48

VS 150

G59401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G59401

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2707 N. Howard St.
(c) Hospital or institution: 12-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2707 N. Howard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marion G. Wimmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ernest E. Wimmer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1893

8. AGE: Years	Months	Days	If less than one day
54	9	8	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Hutchinson Grouch
13. Birthplace Md.

MOTHER
14. Maiden Name Naomi ------
15. Birthplace Md.

16 (a) Informant Mr. Ernest E. Wimmer
(b) Address 2707 N. Howard St.

17 (a) Burial (b) Date thereof Jan. 26/48.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director Harry A. Nuttle
(b) Address 4101 Edmondson Ave.

19 (a) JAN 26 1948 (b) Washington Wilson Registrar, M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22/48. 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19 40, to Jan 22 19 48.
and that I last saw h alive on Jan 22 19 48.

Immediate cause of death Asthenia - Carcinoma of Colon — Duration 2 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Nov. 20 - 1947

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert K. Mortimer Jr. M. D.
Address 2106 St Paul St Date signed 1/24/48

VS 150

G59402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1061 B

Registered No. G59402

Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1829 W. LOMBARD ST
(c) Hospital or institution: 19-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1829 W. LOMBARD ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FRANK COOK

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-16-0154

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife MARY I ZIMMERMAN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 8, 1897

8. AGE: Years	Months	Days	If less than one day
50	9 10	14	hr. min.

9. Birthplace OKLAHOMA (Town, county, and state)

10. Usual Occupation WATCHMAN

11. Industry or business CROWN CORK & SEAL CO.

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant MRS FRANK COOK
(b) Address 1829 W. LOMBARD ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 25 1948 (month) (day) (year)
(c) Cemetery or crematory Loraine Pk
Location Woodlawn, Md.

18 (a) Funeral director Harry F. Weyler
(b) Address 401 Edmondson Ave

19 (a) JAN 26 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 22 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Jan 22 1948, and that I last saw him alive on Jan 21 1948.

Immediate cause of death	Duration
Myocardial Failure	3 mos.
Due to Emphysema	2 yrs.
Due to Chronic Bronchitis	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Morris B. Schreiber M. D.
Address 54 S. Fulton Ave Date signed 1-23-48

VS 150

X

C59403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. C59403

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 519 N. Carey St.
(c) Hospital or institution: 18-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cora Corrine Johnson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Widow

6 (b) Name of husband or wife Eugene Johnson.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 22, 188?

8. AGE: Years	Months	Days	If less than one day
60	11	-	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles C. Johnson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sarah M. Lee
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Ida Mason.
(b) Address 519 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 26, 1948 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location

18 (a) Funeral director Mrs Katie K. Williams
(b) Address 922 N. Arlington Ave. Baltimore, Md.

19 JAN 26 1948 (Date rec'd by registrar) (b) Transit or Removal Permit No. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1948, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1947, to Jan 22 1948; and that I last saw her alive on Jan 21 1948.

Immediate cause of death Acute myocarditis.

	Duration
Due to 1 Chronic nephritis	2 mos.
Due to 2 Hypertension	2 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles L Mentzer M. D.
Address 1730 Linden Ave. Date signed 1-26-48

VS 150

* correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The PRINT PLAINLY, WITH UNFADING INK.

G59404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G59404

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6 E. Read St.
(c) Hospital or institution: ********** 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) ***
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 E. Read St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Delia T. Tully

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
***	***	F	W	Single

6 (b) Name of husband or wife ********
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 1870

8. AGE: Years	Months	Days	If less than one day
78	0	15	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation at home
11. Industry or business ****

FATHER
12. Name Patrick Thomas Tully
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Parker
15. Birthplace Scotland

16 (a) Informant Mr. Joseph P. Tully
(b) Address 257 Valentine Lane, Yonkers

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore City

18 (a) Funeral director H. W. Meas and Son
(b) Address 805 N. Calvert St.

19 (a) JAN 26 1948 (Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24th 1948, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1947 to Jan 24th 1948, and that I last saw her alive on Jan 24 1948

Immediate cause of death Cardiac embolism
Myocardial Insufficiency — Duration
Due to Arterio-Sclerosis
Due to Arterio-Sclerotic gangrene of foot
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature J. A. Charles M. D.
Address 1300 N. Calvert St Date signed Jan 25/48

VS 150

C59405 GM. 88460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. C59405

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4215 White Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas James Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Pauline
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20 -1869

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Davis (D)
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth Dundas (D)
15. Birthplace Ireland

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26 41 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Balto

18 (a) Funeral director J. J. Leach Co
(b) Address 534 Hoosier Co

19 (a) JAN 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23 - 1948 at 5.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6 - 10 - 1944 to Jan. 23 - 1948, and that I last saw him alive on Jan 23 1948.

Immediate cause of death: Bronchopneumonia — Duration: 1 wk

Due to

Due to

Other Conditions: Hypertension Cerebrovascular Disease — gm

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Anatomic

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Rahman Jr M. D.
Address Bal City Hosp Date signed 1/29/48

VS 150

107

CORRECTIONS, IF ANY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 309

Registered No. G59406

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 E Carlton St.
(c) Hospital or institution: — | 8-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) — —
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 33 E. Carlton St. (If rural give location)
(e) Citizen of foreign country? Cda (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Oliver

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Alvin P. Oliver
6 (c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): Feb. 22-1898

8. AGE: Years: 49 | Months: 11 | Days: 1 | If less than one day: ... hr. ... min.

9. Birthplace: Connecticut, Conn. (Town, county, and state)
10. Usual Occupation: House wife
11. Industry or business: At Home

FATHER
12. Name: John Hogan
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Ireland

16 (a) Informant: Alvin P. Oliver
(b) Address: 33 E Carlton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 26 Jan 48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: F. B. Shubert & Son
(b) Address: 1300 Eutaw Place

19 JAN 26 1948 (Date rec'd by registrar) (b) Hunter's for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 23 1948 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20 1947 to Jan. 21 1948, and that I last saw h[illegible] alive on Jan. 21 1948

	Duration
Immediate cause of death: Cancer of liver	Unkn.
Due to: Unknown	
Due to:	
Other Conditions: Yes.	Years.

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Charles Townsend Jr. M.D.
Address: 910 W. Lombard St. Date signed: 24 Jan. 48.

V S 150

124 R

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C59407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. C59407

TYPEWRITER, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 831 N. Fremont Street
(c) Hospital or institution: 17-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 831 N. Fremont Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BESSIE A. BATSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Negro	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1894

8. AGE: Years	Months	Days	If less than one day
53	7	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name William Johnson
13. Birthplace Va.

MOTHER
14. Maiden Name Malinda Gardner
15. Birthplace Charles County, Md.

16 (a) Informant Malinda Matthews
(b) Address 831 N. Fremont Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Arbutus, Md.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Avenue

19 (a) JAN 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23, 1948 at 9:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-17 1948 to 1/23 1948 and that I last saw h[illegible] alive on 1/23 1948.

Immediate cause of death [illegible] Pneumonia — Duration 6 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. J. Hatcher

Address 1 [illegible] Parkin Date signed 1/26/48 M. D.

VS 153

G59408

GM. 116784

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered G59408

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1641 N. Carey ST.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Reba Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Van Lear

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5 -1915

8. AGE: Years 32 | Months 1 | Days 19 | If less than one day hr. min.

9. Birthplace Md. Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Rev. John Lindsey

13. Birthplace VA.

MOTHER 14. Maiden Name Annie Morgan

15. Birthplace VA.

16 (a) Informant Records B'lto. City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 28, 1948 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk.

Location Arbutus, Md.

18 (a) Funeral director Charles R. Law

(b) Address 802 Madison Avenue

19 (a) JAN 26 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1948, at 3.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 21-1948, to Jan. 24-1948, and that I last saw her alive on Jan. 24-1948.

Immediate cause of death	Duration
Miliary Tuberculosis	1-3 mos.
Due to Tuberculous Meningitis	3 weeks
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Laurence Lee Jr. M. D.

Address Baltimore City Hosp Date signed 1-25-48

X

If the correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The

G59409

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G59409

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23-1
(c) Hospital or institution: South Baltimore Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 112 Rogewalk Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY T. WILSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	married

6 (b) Name of husband or wife Sears Wilson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10-1920

8. AGE: Years	Months	Days	If less than one day
27	7	17	hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation at stone

11. Industry or business

FATHER
12. Name Charles Thomas
13. Birthplace W. Va

MOTHER
14. Maiden Name Lottie Milland
15. Birthplace md

16 (a) Informant Lottie Thomas
(b) Address 609 S. Sharp St

17 (a) Burial (b) Date thereof 1-27-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James A Stayes
(b) Address 1142 Hollins St

19 JAN 26 1948 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23 1948 at 1 30 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Generalized miliary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chas E. Merrill M.D.
Medical Examiner.

Date signed 1/23/48

VS 151

Information should be carefully supplied. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

LANTY

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

931

Registered No. G59410

G59410

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St. 10-1
(c) Hospital or institution: Home for the Aged Sisters
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lanty Ryan
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years	Months	Days	If less than one day
83			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Timothy Ryan
13. Birthplace

MOTHER
14. Maiden Name Mary Walsh
15. Birthplace

16 (a) Informant Sister Louise Teresa
(b) Address 120 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 28 1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wunderlich
(b) Address 900 E. Biddle St

19 (a) JAN 26 1948 (Date rec'd by registrar) (b) Entering to Hill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23 1948, at 7:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10- 1947, to Jan 23 1948, and that I last saw him alive on Jan 23 1948.

Immediate cause of death	Duration
Edema Lungs	2 days
Due to Cardiac Asthma	3 yrs
Due to	
Other Conditions Chr. Myocarditis	5 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Ave Date signed 1/24/48

VS 150

HORRIS

C59411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C59411

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St 10-1
(c) Hospital or institution: Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: W.

6 (b) Name of husband or wife: Barbara Harris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1874

8. AGE: Years 73 | Months 21 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name No knowledge
13. Birthplace

MOTHER
14. Maiden Name No knowledge
15. Birthplace

16 (a) Informant Sallie Linder 7 Te Pora
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 29 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 E. Biddle St

19 (a) JAN 26 1948 (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26 1948, at about 11:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 - 1948 to Jan 26 - 1948, and that I last saw him alive on Jan 24 1948.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to	
Due to	
Other Conditions Arteri-Sclerosis	5 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.

Address 1631 E. North Ave Date signed 1/26/48

VS 150

X

PRINT CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C59412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832a

Registered No. C59412

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3716 - 2nd St.
(c) Hospital or institution: 25.4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE MD (If outside city or town limits, write RURAL and give town)
(d) Street No. 3716 - 2nd St Brooklyn (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JENNIE G BARTENS (GIBSON)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM.	WHITE	WIDOW

6 (b) Name of husband or wife FRED BARTENS
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) NOV 11 1867

8. AGE: Years	Months	Days	If less than one day
80	2	13	hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)
10. Usual Occupation HOUSE WORK
11. Industry or business AT HOME

FATHER
12. Name MATHEW IMHOFF
13. Birthplace BALTO MD

MOTHER
14. Maiden Name AGNES M. LEIDLEICH
15. Birthplace GERMANY

16 (a) Informant AGNES GALLAGHER
(b) Address 1134 GORSUCH AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN 27 48 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location A A Co

18 (a) Funeral director Bernard G. Hasle
(b) Address 121 E West St

19 (a) JAN 26 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 24 1948, at 8:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 1948 to 1/24 1948. and that I last saw h[illegible] alive on 1/23 1948.

Immediate cause of death	Duration
Due to Cerebral hemorrhage	
Due to Pneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Rubenstein M. D.
Address 203 Paloposa Ave Date signed 1/24/48

VS 150

G59413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

G59413
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1600 N. Montford Ave
(c) Hospital or institution: G.2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1600 N. Montford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Hyman
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-10-3696
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Ortlea Hyman
6 (c) If alive, give age 50 years
7. Birth date of deceased (mo., day, yr.) June 13 1897
8. AGE: Years 50 Months 7 Days 9 If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Queen Brothers
FATHER 12. Name William H. Hyman
13. Birthplace Baltimore Md
MOTHER 14. Maiden Name Susie Bibby
15. Birthplace Dorchester Co. Md
16 (a) Informant Ortlea Hyman
(b) Address 1600 N. Montford Ave
17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1-26-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Frederick Road
18 (a) Funeral director Jos. C. Miller Inc.
(b) Address 2435 E. Oliver St
19 (a) JAN 26 1948 (date rec'd by registrar) (b) Huntingtown Maryland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22 1948, at M
21. I certify that death occurred on the date above stated; that I attended deceased from January 10 1948 to January 22 1948 and that I last saw deceased alive on January 22 1948.

Immediate cause of death: Lobar Pneumonia and Cardiac Dilatation
Due to: Influenza
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration: 1 day; 12 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Albert Rosenberg M. D.
Address 3025 E. North Ave Date signed 1-24-48

VS 150

G59414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G59414 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto Md
(b) Street address 1545 Leslie ST
(c) Hospital or institution: 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) no
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1545 Leslie St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Enoch Wright

3 (b) If veteran, name war no

3 (c) Social Security Account No. no

4. Sex M | 5. Color or race Col | 6 (a) ~~Single, married, widowed, or divorced~~ Yes

6 (b) Name of ~~husband or~~ wife Bertha Wright

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23 1887

8. AGE: Years 70 | Months 10 | Days 9 | If less than one day hr. min. 1877

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Walter Wright
(b) Address 1545 Leslie

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director George G. Kelson
(b) Address 1303 Presstman ST

19 JAN 26 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1948 at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 24 1948 to 1-23-1948 and that I last saw him alive on 1-19-1948.

Immediate cause of death Cerebral Hemorrhage

Duration 1 da

Due to Hypertension

Due to Apoplexy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. K. Boyd M. D.

Address 1133 Monroe Date signed 1/24/48

VS 8

G59415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G59415 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 N. Rose St.
(c) Hospital or institution: N.2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 703 N. Rose St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clement Loskot

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Lena (nee Dobra)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/23/1874

8. AGE: Years 73 | Months 1 | Days 28 | If less than one day hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Lena Dobra Loskot - wife
(b) Address 703 N. Rose St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/48 (month) (day) (year)
(c) Cemetery or Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-3-5 E. Madison Street

19 (a) JAN 26 1948 (Date rec'd by registrar) (b) Permit issued for Interment

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1948, at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Jan 21 1948, and that I last saw h[illegible] alive on Jan 21 1948

Immediate cause of death Coronary Occlusion — Duration 1/20/48

Due to Ch. Myocarditis — 1/1945

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Rysanek M.D.
Address 801 Reedbird Ave Date signed 1/23/48

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. WRITE PLAINLY, WITH UNFADING INK.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G59416 ✓ G59416 95B

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15 N. Bradford St.
(c) Hospital or institution: 6-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 15 N. Bradford St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicola Di Pinto

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of ~~husband~~ or wife Assunta (nee Caraffa)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1901

8. AGE: Years	Months	Days	If less than one day
46	7	7+	hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jiuseppi DiPinto
13. Birthplace Italy

MOTHER 14. Maiden Name Maria Michele Pepe
15. Birthplace Italy

16 (a) Informant Assunta DiPinto - wife
(b) Address 15 N. Bradford Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/26/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-3-5 E. Madison Street

19 (a) 1919 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1948, at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 11 1948 to Jan 22 1948, and that I last saw him alive on Jan 21 1948.

Immediate cause of death Cardiac failure — Duration

Due to Rheumatic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature [illegible]
Address 333 N. Eutaw Date signed 1/22/48. M. D.

VS 150

Registrar [illegible]

G59417

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. G59317

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3604 Mohawk Ave.
(c) Hospital or institution: Anderson Nursing Home 287
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4700 Springdale Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Gertrude D. Jackson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1857

8. AGE: Years	Months	Days	If less than one day
90	6	24	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Contractor - retired
11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. John Moale
(b) Address 4503 Springdale Ave.

17 (a) Burial (b) Date thereof 1/27/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Loudon Park
Location 3801 Frederick Ave., Baltimore

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) JAN 26 1948 (b) Signature Thurston Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1948, at 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 29 1947, to Jan 24 1948, and that I last saw him alive on Jan 2nd 1948.

Immediate cause of death	Duration
Cardiac Decompensation	2 days
Due to Hypertrophy	3 years
Due to Arteriosclerosis	5 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Talbot T. Fleischmann M. D.
Address 6 E. Biddle St. Date signed

VS 150

X

Please write plainly, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59418

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G59418
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 222 N. Calhoun St.
(c) Hospital or institution: 19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 222 N. Calhoun St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Julia Smith.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Widow

6 (b) Name of husband or wife John Thomas Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 15, 1882

8. AGE: Years	Months	Days	If less than one day
65	4	8	hr. min.

9. Birthplace Charles County, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Matilda Butler.
15. Birthplace Charles Co. Md.

16 (a) Informant Herman Smith.
(b) Address 222 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 26/1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion.
Location

18 (a) Funeral director Mrs. Katye R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 26 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23, 1948, at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10- 1948 to 1-23- 1948
and that I last saw h. alive on 1-19- 1948

Immediate cause of death C. valvular Disease of heart — Duration 16 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John E. L. Campbell M. D.
Address 639 h. Carey St. Date signed 1-26-48

G59419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. G59419

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave + Madison St
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Havre de Grace (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 Lewis St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Warren Hill

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/25/1875

8. AGE: Years	Months	Days	If less than one day
71	11	20	13 hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Isaac Hill
13. Birthplace Virginia

MOTHER
14. Maiden Name Annie Hill
15. Birthplace Virginia

16 (a) Informant: Mrs Mary F Christie
(b) Address 502 Lewis St. H-de-G. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 21 47 (month) (day) (year)
(c) Cemetery or crematory St James
Location Havre de Grace, Md

18 (a) Funeral director Elmer E Bullock
(b) Address 536 Lewis St. H. de G. Md

19 (a) JAN 26 1948 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17 1947, at 8 03 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24 1947, to Dec 17 1947, and that I last saw him alive on Dec 17 1947.

Immediate cause of death Malnutrition — Duration:
Due to Carcinoma of esophagus
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: 11-25-47
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature O. James Hunt M. D.
Address Maryland General Hosp. Date signed 12-19-47

G59420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. G59420

The information should be carefully supplied. The accuracy important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st Stt.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mo. 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 mo. 2 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Y. (b) County
(c) City or town Buffalo, New York
(If outside city or town limits, write RURAL and give town)
(d) Street No. 122 Seneca St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SHEEHAN, Patrick Timothy

3 (b) If veteran, name war

3 (c) Social Security Account No. 122-10-0075

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 13, 1882

8. AGE: Years	Months	Days	If less than one day
65	10	9	hr. min.

9. Birthplace New York, N. Y.
(Town, county, and state)
10. Usual Occupation seafarer (galley)
11. Industry or business

FATHER
12. Name Timothy Sheehan
13. Birthplace Ireland

MOTHER
14. Maiden Name Ann Drisscon
15. Birthplace Ireland

16 (a) Informant Records, US. Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof 1-27-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director Lilly & Zeilsdorf
(b) Address 403 S. Wolfe St.

19 (a) JAN 26 1948 (b) Huntington Williams M.D.
(Date received by registrar)

VS 15b

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22 1948, at 7:45PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20 1947 to Jan 22 1948, and that I last saw h im alive on Jan. 22, 1948.

Immediate cause of death	Duration
Carcinoma of sigmoid colon	15 mos
with metastases to liver,	UNKNOWN
Due to regional nodes and left ureter.	
Due to Pyonaphrosis, left	UNKNOWN
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon, Clinical Dir.
Address U S Marine Hospital Date signed
Baltimore, Md.

G59421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 1 B

Registered No. G59421

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1732 Montpelier Street

(c) Hospital or institution:

9-7

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1732 Montpelier Street (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME August L. Pranke

3 (b) If veteran, name war: Spanish-American

3 (c) Social Security Account No. 213-28-1828

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Josephine L. Pranke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15-1880

8. AGE: Years 67 | Months 11 | Days 8 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER

12. Name August Pranke

13. Birthplace Germany

MOTHER

14. Maiden Name Cecelia Rontitte

15. Birthplace Germany

16 (a) Informant Mrs. Josephine L. Pranke

(b) Address 1732 Montpelier St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 27-1948 (month) (day) (year)

(c) Cemetery or crematory Western

Location Baltimore Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3621 Falls Road

19 JAN 26 1948 (Date rec'd by registrar) Walter for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23-1948, at 5-30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/16 1946, to 1/23 1948 and that I last saw h(im) alive on 1/21 1948.

Immediate cause of death Coronary occlusion

Due to Arteriosclerosis

Due to

Other Conditions Carcinoma of prostate

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Theo L. Grayson M. D.

Address 2502 Harford Rd. Date signed 1/26/48

VS 150

Please answer all questions. Items of information should be carefully supplied. The space is especially important. Physicians: please write the causes of death clearly and legibly.

G59422 3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G59422 Registered No.

XB-116484

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 1-5

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 244 S. Collington Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph M. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Clara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1- 1895

8. AGE: Years 52 | Months 9 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county and state)

10. Usual Occupation Ship Worker

11. Industry or business Beth. Steel Co

FATHER 12. Name Mitchell Miller (D

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Pauline Gerley or Garlay (D

15. Birthplace Baltimore, Md.

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 27-1948 (month) (day) (year)

(c) Cemetery or crematory Schowty Cem. Location O'Donnell St & Ky

18 (a) Funeral director John G. Connelly

(b) Address 448 Eastern Ave.

19 (a) JAN 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23- 1948, at 11P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10- 1948 to 1-23- 1948 and that I last saw h. im alive on 1-23 1948.

Immediate cause of death	Duration
Broncho Pneumonia	3days.
Due to Carcinoma OF stomach with	1year.
Due to Carcinomatosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 1-21-48

Major findings of operation: Carcinoma OF Stomach

of autopsy: Same

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. E. Geary M. D.

Address 4940 Eastern Ave Date signed 1-25-48

VS 150

C59423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered C59423

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. USE INK, WITH UNFADING INK.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 208 N. Payson St.

(c) Hospital or institution: 20-1

(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 208 N. Payson St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward C. Dunn

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary A. McKenna

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Sept 21st 1878

8. AGE: Years 69 | Months 4 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Guard

11. Industry or business U.S. Government

FATHER 12. Name Edward P. Dunn

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Julia C. Unknown

15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Margaret V. Murphy

(b) Address 208 N. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.

Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Cowan & Son

(b) Address 901-03 N. Collins St.

19 (a) JAN 26 1948 (Date rec'd by registrar) (b) Cunningham Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25th 1948, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1945 to Jan 25 1948, and that I last saw him alive on June 25 1948.

	Duration
Immediate cause of death Gastric Hemorrhage resulting from ruptured arteriosclerotic ulcer	2 days
Due to	
Due to	
Other Conditions Hypertension C.V. Disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John F. Coalahan M. D.

Address 24 N. Fulton Ave. Date signed 1/26/48

VS 150

118

G59424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G59424

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Lombard Sts. 26-1
(c) Hospital or institution: University Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23da
(e) Length of stay in Baltimore (yrs., mos., or days) 70 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 White Ave.
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME Mrs Lydia A. Kable

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
None	Yes	F	W	Widow

6 (b) Name of husband or wife Clarence C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 15, 1877

8. AGE: Years	Months	Days	If less than one day
70	10	11	hr. min.

9. Birthplace Wilmington Del.
(Town, county, and state)
10. Usual Occupation Retired Bookkeeper
11. Industry or business --

FATHER
12. Name James E. Armstrong
13. Birthplace Wilmington, Del.

MOTHER
14. Maiden Name Harriet R. Winchester
15. Birthplace Cecil County, Md.

16 (a) Informant Mrs. Morris W. Evans
(b) Address 2871 Pelham Ave.

17 (a) Burial (b) Date thereof 1/30/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Ave. Baltimore, Md.

19 (a) JAN 26 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-26 1948 at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5 1948 to 1-26 1948 and that I last saw her alive on 1-25- 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to hypostasis	
Due to glomerulo nephritis	
Other Conditions arteriosclerosis possible carcinoma of stomach	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard E. Kable M. D.
Address 1505 W. Lanv. Date signed 1-26-48

VS 153

G59425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G59425 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 15-13
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) 44 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2401 Oswego Ave.
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME Robison, J. Arley

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: ----

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Elizebeth J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1, 1890

8. AGE: Years 57 | Months 1 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Penna.
(Town, county, and state)

10. Usual Occupation: Supt. Transportation

11. Industry or business: Hendler Creamery Co.

FATHER
12. Name: Augusta A. Robison
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Isabelle Hewett
15. Birthplace: Penna.

16 (a) Informant: Mrs. Elizebeth J.H. Robison
(b) Address: 2401 Oswego Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/48 (month) (day) (year)
(c) Cemetery or crematory: ~~xxxxx~~ Druid Ridge
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS INC
(b) Address: North & Pa. Aves; Balto., Md.

19 (a) JAN 26 1948 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 Jan 19 48, at 11 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 Jan 19 48 to 25 Jan 19 48, and that I last saw h(im) alive on 25 Jan 19 48

Immediate cause of death: Myocardial Infarction — Duration: 2 wks

Due to: Arteriosclerotic Ht. disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Mami H. Dami M. D.

Address: Sinai Hosp Date signed 1-25-48

VS 150

Physicians: please write the causes of death clearly and legibly. The

G59426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G59426

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Josephs Hosp
(c) Hospital or institution: 27-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) --

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6224 Fairdel Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest A. DePuey SR.

3 (b) If veteran, name war None

3 (c) Social Security Account No. -----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Widowed

6 (b) Name of husband or wife Mary E. DePuey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/1/48 1892

8. AGE: Years	Months	Days	If less than one day
55	1	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Carpenter
11. Industry or business Morris & Co.

FATHER
12. Name James A. De Puey
13. Birthplace NYC

MOTHER
14. Maiden Name Emma Lee Funk
15. Birthplace Hagerstown, Md.

16 (a) Informant Mr. W.R. De Puey
(b) Address 3013 California Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Woodlawn
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves; Balto., Md.

19 (a) JAN 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Jan. 1948, at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D.
Medical Examiner.
Date signed 23 Jan. 1948

VS 131

Notice: age is especially important. Physicians: please write the causes of death clearly and legibly. The items of information should be carefully supplied. The

G59427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G59427

Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly. USE PENCIL, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3121 St. Paul St. 12-2
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Boulevard Apts., 3121 St. Paul St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Robert Frainie

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Catherine Dengas Frainie
6 (c) If alive, give age: 2 years

7. Birth date of deceased (mo., day, yr.) Apr. 30, 1874

8. AGE: Years: 73 | Months: 9 | Days: 23 | If less than one day: hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Builder & Contractor

11. Industry or business

FATHER
12. Name Charles Frainie
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret -
15. Birthplace Germany

16 (a) Informant Mrs Catherine Frainie
(b) Address 3121 St. Paul St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 26 1948 (Date rec'd by registrar) (b) Tunstin Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1948, at 8:36 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27 1947 to 1/23 1948, and that I last saw him alive on 1/23 1948

Immediate cause of death	Duration
Renal Failure	
Azotemia	
Due to Bilateral pyonephritis	
Due to Benign Prostatic Hypertrophy	
Other Conditions Coronary Occlusion	
Posterior Coronary Artery	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Pyonephritis, BPH-Coronary Occ.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Neal Fitzpatrick M.D.
Address St Joseph's Hosp Date signed 1/27/48

V S 150

G59428 #846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124a

Registered No. G59428

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins 26-11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6032 E. East Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bertha M. Johnson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Frank A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-30-02

8. AGE: Years 45 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James D. Weaver
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Shorty
15. Birthplace Md.

16 (a) Informant Records.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto; Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa Aves Balto; Md

19 (a) JAN 26 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23 1948, at 10 H P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 9 1948 to Jan 23 1948 and that I last saw her alive on Jan 23 1948

Immediate cause of death — Duration
Hypatic Coma — 1wk
Due to Sarcoma Arrhosis — yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. A. Sisson
Address Johns Hopkins Hosp. Date signed 2 Jan 48 M. D.

VS 150

X

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The certificate must be typed, WITH UNFADING INK.

G59429

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

G59429 Registered No.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mercy Hospital
(c) Hospital or institution: Calvert St. 27-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 Winston Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH P. DAIGER

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	212-09-0449

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Cecilia Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jun. 14, 1897

8. AGE: Years	Months	Days	If less than one day
50	7	10	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Advertising
11. Industry or business --

FATHER
12. Name JOHN A. DAIGER
13. Birthplace Maryland

MOTHER
14. Maiden Name IRENE A. HUBBARD
15. Birthplace Maryland

16 (a) Informant wife
(b) Address 1412 Winston Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ New Catherdral
Location Baltimore, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves; Balto., Md.

19 (a) JAN 26 1948 (Date rec'd by registrar) (b) Huntington Hillsboro, W. Va. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24 1948, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24 1948 to Jan 24 1948 and that I last saw him alive on Jan 24 1948.

Immediate cause of death: Cerebral hemorrhage — Duration
Due to: Hypertension
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Lane M. Finnigan M. D.
Address Mercy Hospital Date signed Jan 24 48.

G59430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G59430 Registered No.

Information should be carefully supplied. The Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3713 Manmon Ave.
(c) Hospital or institution: -- 28-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) ---

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3713 Marmon Ave.
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME JOSEPHINE M. SCHOONMAKER

3 (b) If veteran, name war	3 (c) Social Security Account No.
***	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Henry S.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1875

8. AGE: Years	Months	Days	If less than one day
73	0	20	hr. min.

9. Birthplace Fort Wayne, Ind. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name James J. Fox
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellan Gamble
15 Birthplace Unknown

16 (a) Informant Henry S. Schoonmaker
(b) Address 3713 Marmon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/48 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ New Cathedral
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address North & Pa. Aves; Balto., Md.

19 (a) JAN 26 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24 1948, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1945 to Jan. 24 1948 and that I last saw her alive on Jan. 24 1948.

Immediate cause of death 1) - Cerebral Hemorrhage — Duration 8 days
Due to Hypertensive Heart
Due to Disease — 5 yrs.
Other Conditions -

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Earl L. Chambers M. D.
Address 4108 Liberty Hts Date signed 1/26/48

VS 150

G59431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G59431 Registered No.

The accuracy and completeness of information should be carefully supplied. The accuracy is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2034 N. Washington St. 8-5
(c) Hospital or institution: --

(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) --

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2034 N. Washington St. (If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME JOHN FULTON BOSLEY

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 216-07-2151

4. Sex: M F M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lida Downes Bosley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 18, 1872

8. AGE: Years 75 | Months 8 | Days 6 | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: Salesman

11. Industry or business: Bagby Furniture Co.

FATHER
12. Name John W. Bosley
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name: Marhha McElnee
15 Birthplace: Unknown

16 (a) Informant: Mr. Edgar B. Bosley
(b) Address: 1206 Lakeside Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~: Parkwood
Location: Baltimore, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS INC
(b) Address: North & Pa. Ave; Balto., Md.

19 (a) JAN 26 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 21 1947 to Jan 24 1948 and that I last saw h im alive on Jan 24 1948.

Immediate cause of death	Duration
Pulmonary edema	4 Days
Due to Cardio Vascular disease	4 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M Bauman and Lood M. D.
Address 2200 Garrison Blvd Date signed 1-26-48

G59432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G59432 Registered No.

PRINT PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3014 Pinewood Ave
(c) Hospital or institution: 27-5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3014 Pinewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Enrico Monte

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of ~~husband or~~ wife: Josephine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29 1885

8. AGE: Years 62 | Months 9 | Days 26 | If less than one day: hr. min.

9. Birthplace Castrogiovanni Italy (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Vincenzo Monte
13. Birthplace Italy

MOTHER
14. ~~Maiden~~ Name Giuseppina BARBARINO
15. Birthplace Italy

16 (a) Informant Louis Monte
(b) Address 3014 Pinewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 27/1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St. Huntington Williams, M.D.

19 (a) JAN 26 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24 1948 at 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1947, to Jan. 1948 and that I last saw h[illegible] alive on Jan 23 1948.

Immediate cause of death: Bronco-pneumonia — Duration 72 hrs.
Due to Carcinoma of Sigmoid
Colon & metastasis
Due to Ulceration Bowel, etc.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1946

Major findings of operation: Ca Sigmoid colon

of autopsy: none

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Hasson M.D.
Address 4218 Pimlico Rd. Date signed 1-27-48

VS 150

G59433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 50

Registered No. G59433

1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2226 Maryland Ave 12-7
(c) Hospital or institution: Convent of Our Lady of St. Francis
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED: ✓
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2226 Maryland Ave (If rural, give location)
(e) Citizen of foreign country? (~~Yes~~ or No) If yes, name country

3 (a) **FULL NAME** Sister Mary Agatha Rose Lindsay

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8 1885

8. AGE: Years	Months	Days	If less than one day
62	9	15	hr. min.

9. Birthplace Windsor England (Town, county and state)
10. Usual Occupation Catholic Sister
11. Industry or business

FATHER
12. Name William Lindsay
13. Birthplace England

MOTHER
14. Maiden Name Beatrice Herbert
15. Birthplace England

16 (a) Informant Mother Superior
(b) Address St Elizabeths Home

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 26 / 48 (month) (day) (year)
(c) Cemetery or crematory St Elizabeths
Location Oldesse ave Balto Md

18 (a) Funeral director Henry N. Jenkins
(b) Address McCulloh & Richards

19 (a) JAN 26 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Jan. 1948, at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Metastatic carcinoma of breast

Due to Primary carcinoma of breast.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer, Jr. M.D. Medical Examiner
Date signed 26 Jan. 1948

VS 151

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

G59434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G59434 Registered No. 2747

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1613 Waldo St.
(c) Hospital or institution: 7-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 Waldo St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Rhodes
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Col.	Widow

6 (b) Name of husband or wife George
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 12 187 (1947)

8. AGE: Years	Months	Days	If less than one day
75	3	12	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name William Cooper
13. Birthplace Md

MOTHER
14. Maiden Name Lydia ?
15. Birthplace Md

16 (a) Informant Mary Jackson
(b) Address 1613 Waldo St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 27 '48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A-A. County

18 (a) Funeral director Mrs Robt A. Elliott Dept
(b) Address 1129 N. Carlisle St

19 (a) JAN 26 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24 1948, at 11:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1945 to Jan 24 1948, and that I last saw her alive on 1-24 1948.

Immediate cause of death Cerebral Hemorrhage — Duration 7

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arnold B. Ky [illegible] M. D.
Address 501 Cherry Hill Rd. Date signed 1-24-48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C59435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

C59435 Registered No.

Please answer all questions as fully as possible. The accuracy of information should be carefully supplied. The questions are especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1820 Madison Ave.
(c) Hospital or institution: 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1820 Madison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Wilder (Walder)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Married

6 (b) Name of husband or wife Minnie Wilder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 6, 1898

8. AGE: Years	Months	Days	If less than one day
49 50 smt	11	19	hr. min.

9. Birthplace Georgia
(Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name John Wilder
13. Birthplace Georgia

MOTHER
14. Maiden Name Annie Jackson
15. Birthplace Georgia

16 (a) Informant Minnie Wilder
(b) Address 1526 N. Dallas Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-30-48 (month) (day) (year)
(c) Cemetery or crematory M.T. Calvary cemetery
Location Md.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) JAN 26 1948 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 19 48, at 6. P M

21. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.

Date signed 1-26-48

G59436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G59436 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 715 W. Fayette st
(c) Hospital or institution: 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 715 W. Fayette st (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James S. Kanaris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Julia

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 62 yrs Months Days If less than one day hr. min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Stamas Kanaris
13. Birthplace Greece

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Daughter
(b) Address 715 W. Fayette st

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Greek Cem
Location Windsor Mill Rd

18 (a) Funeral director Kambos Funeral
(b) Address 440 E. North ave

19 (a) (Date received by registrar) JAN 26 1948 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/25/48 19 , at 3 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/18/48 19 , to 1/19/48 19 , and that I last saw h alive on 1/19/48 19 .

Immediate cause of death	Duration
Acute Myocarditis	Few days
Due to Cancer of Stomach	months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allen T. Downs M. D.
Address 402 Edmondson Ave Date signed 1/26/48

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

#49 B59437 BALTIMORE CITY HEALTH DEPARTMENT C59437

CERTIFICATE OF DEATH 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2639 Loudoun Ave (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Gaill

3 (b) If veteran, name war None

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1882

8. AGE: Years 65 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name Ludwig Zirkenbach
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28-48 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. County, Md.

18 (a) Funeral director Geo. L. Schwab
(b) Address 201 Frederick Avenue

19 (a) JAN 28 1948 (b) Dated by registrar Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24 1948 at 4:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 16 1948 to Jan. 24 1948 and that I last saw her alive on Jan. 24 1948

Immediate cause of death cardiac failure — Duration

Due to thrombophlebitis of femoral vein
? myocardial infarction — 1 wk

Due to pneumonia
intestinal obstruction

Other Conditions obesity
emphysema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. A. Gregory M. D.
Address Johns Hopkins Hosp. Date signed 1/30/48

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59438 BALTIMORE CITY HEALTH DEPARTMENT G59438
448976 CERTIFICATE OF DEATH 46M

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 56 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2624 Maynard Ave FRANKLINTOWN, Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lemuel Phillips
3 (b) If veteran, name war None
3 (c) Social Security Account No. None
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Maggie Phillips
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 5-9-72
8. AGE: Years 75 Months 8 Days 16 If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business
FATHER 12. Name Basil Phillips
13. Birthplace Md. ?
MOTHER 14. Maiden Name Julia Beacraft
15. Birthplace Md. ?
16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-27-48 (month) (day) (year)
(c) Cemetery or crematory New Oakland
Location Carroll County, Md
18 (a) Funeral director George L. Schwab
(b) Address 210 Frederick Ave.
19 (a) (b) Registrar
Date received JAN 28 1948 Westminster, Md.

MEDICAL CERTIFICATION
20. DATE OF DEATH Jan - 25 - 1948 at 10 M
21. I certify that death occurred on the date above stated; that I attended deceased from 1-20- 1948 to 1-25- 1948 and that I last saw him alive on 1-25- 1948.
Immediate cause of death CORONARY OCCLUSION — Duration None
Due to
Due to
Other Conditions LARGE LEG ULCER ? GASTROINTESTINAL CANCER
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Richard C Clay M. D.
Address Johns Hopkins Hosp. Date signed Jan 25 1948

VS 150

94a

CAUTION: THIS CERTIFICATE, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

To Be Approved By MK G59439

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G59439 Registered No. 477

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: CATON & WILKENS AVE.
(c) Hospital or institution: ST. AGNES HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 MOS. 10 DYS
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 529 W. 27th St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME RANDOLPH DONALDSON

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
None	None	MALE	WHITE	WIDOWED

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25, 1881

8. AGE: Years	Months	Days	If less than one day
66	1	29	hr. min.

9. Birthplace — Md. (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name Randolph Donaldson
13. Birthplace MD.

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace MD.

16 (a) Informant Mr. Leslie Donaldson
(b) Address — 2511 St. Paul Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemt.
Location Woodlawn

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address 1948, North & Pa. Aves.

19 (a) JAN 26 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/24/ 19 48 at 7:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-18 19 47 to 1/24 19 48
and that I last saw h— alive on 1/24/ 19 48

Immediate cause of death Carcinoma of lung with metastasis to brain. — Duration

Due to

Due to

Other Conditions INTERTROCHANTERIC FRACTURE OF LEFT FEMUR
(Include pregnancy within 3 months of death)
Date of operation 10/19/47
Major findings of operation: PLATE & SCREW SPLINT APPLIED.
of autopsy: Ca of lung & Metastasis to brain

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following.
(a) Accident, suicide, or homicide Accident?
(b) Date of occurrence 10-18-
(c) Where did injury occur? 529 W. 27th Street M
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Struck leg on sofa
23. Signature Howard J. Maddox, M.D.
Address 1100 Cathedral St. Date signed 1/26/48

VS 150

Howard J. Maddox, M.D.

CAUTION: THIS CERTIFICATE, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

G59440 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 516 East 21st Street
(c) Hospital or institution: 9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 East 21st Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANN JANE COLGAN

3 (b) If veteran, name war -----

3 (c) Social Security Account No. -----

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1873

8. AGE: Years 74 Months Days If less than one day hr. min.

9. Birthplace: Fallston, Md. (Town, county, and state)

10. Usual Occupation: Ath Home

11. Industry or business

FATHER
12. Name: Geo. Rahll
13. Birthplace: Italy

MOTHER
14. Maiden Name: Mary Kelly
15 Birthplace: Fallston, Md.

16 (a) Informant: Mrs. Gerard Aiken
(b) Address: 516 E. 21st Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/48 (month) (day) (year)
(c) Cemetery or crematory: St. Johns Cem.
Location: Long Green, Md.

18 (a) Funeral director: WIEDEFELD & SON
(b) Address: GREENMOUNT AVE & 22ND

19 (a) JAN 26 1948 (Date rec'd by Registrar) (b) Registrar: Washington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/23/48 19 , at 9:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1947 to Jan. 23 1948, and that I last saw her alive on Jan. 20 1948.

Immediate cause of death: Myocardial Insufficiency — Duration: 6 mos

Due to: Arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Edward Novak

Address 101 W. Read St. Date signed 1-26-48 M.D.

VS 150

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59441 3 copies

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G59441 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. USE PEN AND INK, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 912 N. Chester st
(c) Hospital or institution: 7.4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 912 N Chester st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma G. Levy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Thomas Levy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18 1881

8. AGE: Years 66 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name Anthony Lavicka

13. Birthplace Bohemia

MOTHER 14. Maiden Name Josephine Satt

15. Birthplace Bohemia

16 (a) Informant Elsie Komadka

(b) Address 912 N. Chester st

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1-27-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balt Md

18 (a) Funeral director Jacob Goodlas

(b) Address 900 N. Chester st

19 JAN 26 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1948, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1948 to Jan 24 1948 and that I last saw her alive on Jan 23 1948.

Immediate cause of death: Coronary Embolus — Duration: 1 day

Due to: Thrombo Phlebitis left leg — 3 weeks

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Pokorny

Address 2200 E Madison Date signed 1/26/48 M. D.

V S 150

G59442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G59442 Registered No.

Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 2713
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 10 (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 Edgevale (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Monroe O. Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Mary Wilson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1889

8. AGE: Years 58 | Months 4 | Days 23 | If less than one day hr. min.

9. Birthplace Keyesville, Virginia (Town, county, and state)

10. Usual Occupation Pres. - Production Credit Corp.

11. Industry or business

FATHER 12. Name Robert A. Wilson

13. Birthplace Virginia

MOTHER 14. Maiden Name Maria Dotson

15. Birthplace Virginia

16 (a) Informant: Mrs. Mary Wilson

(b) Address 503 Edgevale Rd, Balto

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan 26 1948 (month) (day) (year)

(c) Cemetery or crematory

Location Washington, D. C.

18 (a) Funeral director J. Williams Lee Sons Co.

(b) Address 300 - 4th St. N. E.

19 JAN 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-26 1948 at 5:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10 1948 to 1-26 1948 and that I last saw h[illegible] alive on 1-26 1948

Immediate cause of death: Congestive Heart Failure — Duration 1½ da

Due to: Arteriosclerotic Heart disease & resp. Infection — Duration ?

Due to: Coronary occlusion — Duration 4 da

Other Conditions: Bronchopneumonia — Duration 4 da

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard Bowers M. D.

Address Union Memorial Hosp. Date signed 1/26/48

VS 150

X

G59443

449509

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

G59443

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20-2
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 538 N. Pulaski St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clara Derringer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single, married~~, widowed, or divorced Widowed

6 (b) Name of husband or wife Albert M. Derringer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16 1885

8. AGE: Years 62 Months 11 Days 10 If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name John Rapp
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Margaret (Unknown)
15. Birthplace Balto Md

16 (a) Informant Frances Wenker
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 JAN 27 1948 (Date rec'd by Registrar) (Huntington Williams M.D.)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 1948 at 1 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1948 to Jan 26 1948 and that I last saw h.. alive on Jan 26 1948.

	Duration
Immediate cause of death: Myocardial infarction	1 day
Due to: arteriosclerosis	
Diabetes mellitus	13 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Sisson M. D.
Address Johns Hopkins Hosp. Date signed 26 Jan '48

VS 150

Every item of information should be carefully supplied. CORRECTIONS, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59444

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G59444 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 8-7
(d) Length of stay in hospital or inst. (yrs., mos., or days): less than 1 day
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 2014 E. Hoffman St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country:

3 (a) FULL NAME: Chester Henry Green, Jr.

3 (b) If veteran, name war: WW 2

3 (c) Social Security Account No.: 212-20-3479

4. Sex: M

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 3, 1925

8. AGE: Years: 22 | Months: 5 | Days: 22 | If less than one day: hr. min.

9. Birthplace: Balto., Md. (Town, county, and state)

10. Usual Occupation: Fireman-watertender

11. Industry or business: Seafarer

FATHER
12. Name: Chester Henry Green
13. Birthplace: Ohio

MOTHER
14. Maiden Name: Ruth Winter
15. Birthplace: Hagerstown, Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial, cremation, or removal: Burial (b) Date thereof: 1/29/48 (month) (day) (year)
(c) Cemetery or crematory: National
Location: Baltimore Md

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St

JAN 27 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 25 1948, at 9:15A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 25 1948 to Jan. 25 1948, and that I last saw him alive on Jan. 25 1948.

Immediate cause of death: Rheumatic heart disease with mitral stenosis — Duration: Unknown

Due to: — Duration:

Due to: — Duration:

Other Conditions: Pulmonary edema — Duration: 2 wks.

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed: 1/26/48

VS 190

X

G59445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G59445 Registered No.

1. PLACE OF DEATH: 27-7
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2711 Berwick Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Baxter Willis

3 (b) If veteran, name war None

3 (c) Social Security Account No. 213-10-2786

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Lillian A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/11/03

8. AGE: Years	Months	Days	If less than one day
44	3	15	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Balto. Transit Co.

FATHER
12. Name Albert B. Willis
13. Birthplace Va.

MOTHER
14. Maiden Name Evangeline Haynes
15. Birthplace Va.

16 (a) Informant Lillian A Willis
(b) Address 2711 Berwick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (d) JAN 27 1948 (Date rec'd by registrar) (Huntington Williams M.D. Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/26 1948 at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/21 1948 to 1/26 1948 and that I last saw him alive on 1/26 1948

Immediate cause of death	Duration
Cerebral Vascular accident	
Due to Arteriosclerotic Cardiovascular	
Due to Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E May M.D.
Address 1400 N. Caroline Date signed 1/26/48

V S 150

IMPORTANT, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59446

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1107

G59446
Registered No.

Information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 N. Washington St.
(c) Hospital or institution: 8-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1317 N. Washington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lula E. Ballard

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harry L. Ballard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1892

8. AGE: Years 55 | Months 11 | Days 11 | If less than one day: hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John L. Blair
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Susanna Broux
15. Birthplace Baltimore Md.

16 (a) Informant Virginia Burkhardt
(b) Address 203 E. Hoffman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St. Paul St.

19 JAN 27 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-25- 1948, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15- 1948 to 1-25 1948
and that I last saw her alive on 1-25- 1948

Immediate cause of death: Bronchopneumonia — Duration: 5 da.
Due to: acute cold — 10 da.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Rut. E. Blake M. D.
Address Med. arts Bldg Date signed

G58447

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G58447

GM. 116819 V 61

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 25-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2816 Maisel ST. Z 30 (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Mary B. Elder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Charles W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6- 1870

8. AGE: Years	Months	Days	If less than one day
77	5	19	hr. min.

9. Birthplace MD. (Balto.) (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name Frederick R. Bartens
13. Birthplace Germany

MOTHER
14. Maiden Name Arlena E.
15. Birthplace Germany

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 1/28/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) JAN 27 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1- 25 - 1948, at 1:00 PM ~~1:35 PM~~

21. I certify that death occurred on the date above stated; that I attended deceased from 1-23 - 1948, to 1 - 25 - 1948, and that I last saw her alive on Jan. 25 - 1948

Immediate cause of death	Duration
Coma	5-6 days
Due to Diabetes Mellitus	5 yrs.
Due to Pneumonia, Lobar, L.L.L.	5-6 days
Due to organism undet Probable Streptococcal	days
Other Conditions Decedent Gen'l. Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp Date signed 1-26-48

VS 150

X

CORRECTIONS MUST BE MADE, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59448

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. G59448

Type or print, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 19-2
(a) Baltimore City, Maryland
(b) Street address 1400 N. Lexington St.
(c) Hospital or institution:
Aged Women's - Aged Men's Homes
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 N Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cornelius Beatty

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 20 1872

8. AGE: Years 76 | Months — | Days 5 | If less than one day ____hr. ____min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Beatty
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Mary L. Goodwin
15. Birthplace North Point Bala Co. Md.

16 (a) Informant L. H. Read Supt.
(b) Address 1400 N. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Baltimore Md

18 (a) Funeral director Wilson & Dye
(b) Address 1317 E. Fayette

19 (a) JAN 27 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1948, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 1948, to Jan 25 1948, and that I last saw him alive on Jan 25 1948.

Immediate cause of death Cardiac Failure — Duration

Due to Coronary Thrombosis

Due to Generalized Arteriosclerosis with Coronary disease

Other Conditions Hypostatic pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maryland Edward Day M. D.
Address 4-E-33 St - 18 Date signed 1-26-48

V S 150

G59449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

Registered No. G59449

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Agnes Hosp Caton Ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1837 Main St (21)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Eleanor Eaken S 34922

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-12-5662

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife James R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1925

8. AGE: Years 22 | Months 2 | Days 27 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Dallas Tucker

13. Birthplace Md

MOTHER 14. Maiden Name Ruby Harrison

15. Birthplace Md

16 (a) Informant Dallas Tucker

(b) Address Cella Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-48 (month) (day) (year)

(c) Cemetery or crematory Good Shepherd

Location Ellicott City Md

18 (a) Funeral director H C Kyle Holtham

(b) Address Ellicott City Md

19 JAN 27 1948 (Date rec'd by Registrar) (b) [illegible] for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25, 1948, at 4:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/25 1948 to 1/25 1948 and that I last saw h[illegible] alive on 1/25 1948.

Immediate cause of death	Duration
Cardiac failure	
Mitral Stenosis	
Thrombus Atrial Fibrillation	
Due to	
Due to Pregnancy - 6 Mo	1/25/48
Other Conditions Post Mortem Section	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Thrombus Atrial Fibrillation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 1/25/48

VS 190

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

G59450
Registered No.

The information requested, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4331 E Lombard St
(c) Hospital or institution: 26-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4331 E Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Rubin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Jacob
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1857

8. AGE: Years	Months	Days	If less than one day
91 90			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business None

FATHER 12. Name Abraham Abramson
13. Birthplace Russia

MOTHER 14. Maiden Name Beetha ?
15. Birthplace Russia

16 (a) Informant Hyman Rubin
(b) Address 4331 E Lombard St

17 (a) Burial (b) Date thereof Jan, 26, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124- 1126 W North Ave

19 JAN 27 1948 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 1948, at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1936 to Jan 26 1948 and that I last saw h[illegible] alive on 1-26 1948.

Immediate cause of death	Duration
Enteroatlantic Heart Disease	10 years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S H Smith
Address 1223 E. North Ave Date signed 1/26/48

VS 150

X

G59451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 61

G59451
Registered No.

The ... correct age is especially important. Physicians: please write the causes of death clearly and legibly. ... PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hosp. 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2622 Dreamount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Edna Kathaleen Riley

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/12/1889

8. AGE: Years 58 | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Chas Straub
13. Birthplace Balto

MOTHER 14. Maiden Name Dont Know
15. Birthplace Balto.

16 (a) Informant Mrs Mildred Smith
(b) Address 524 E 27th St.

17 (a) Burial (b) Date thereof Jan 27
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Rural

18 (a) Funeral director Wilson Funeral Home
(b) Address 2008 Arlington

19 (a) JAN 27 1948 (b) Huntington, West Virginia
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-23 1948, at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-8 1948 to 1-23 1948; and that I last saw her alive on 1-23 1948.

Immediate cause of death	Duration
Congesting heart failure	
Due to Coronary occlusion	
Due to	
Other Conditions Diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Z May M.D.
Address 1400 N. Caroline St Date signed 1/25/48

V S 150

94a

G59452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G59452 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2214 E Pratt St
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 1-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 2214 E. Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Gardner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-15-72

8. AGE: Years 75 | Months 10 | Days 11 | If less than one day — hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business Butter & Eggs

FATHER
12. Name John Gardner
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Randall
15. Birthplace Balto

16 (a) Informant Mrs Lillian Pierpont
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 28/1948 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location

18 (a) Funeral director Uzzell Funeral Home
(b) Address 2108 Orleans St

19 (a) JAN 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 1948, at 8 15A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 23 1948 to Jan 26 1948 and that I last saw him alive on Jan 26 1948

Immediate cause of death Uremia — Duration 2 wks

Due to arteriosclerotic nephritis

Due to

Other Conditions arteriosclerotic cardiovascular disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Victor A. McKusick
Address Johns Hopkins Hosp Date signed 1/26/48 M.D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43a

Registered No. G59453

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 907 Shields Place
(c) Hospital or institution: 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 907 Shields Place.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1874

8. AGE: Years	Months	Days	If less than one day
73	3	10	hr. min.

9. Birthplace Harford Co., Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Frank Clark
13. Birthplace Md.

MOTHER
14. Maiden Name Laurel Frederick
15. Birthplace Md.

16 (a) Informant M's Rosa Boyer
(b) Address 907 Shields Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Balto. Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 JAN 27 1948 (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH Jan. 24, 19 48 at 9:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 19 48 to Jan 24 19 48, and that I last saw h alive on 19

Immediate cause of death Cerebral hemorrhage — Duration 24hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 963 [illegible] Date signed 1/26/48

V S 150

PRINT PLAINLY, WITH INKING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C59454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (937)

Registered No. C59454

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1380 N. Calhoun St
(c) Hospital or institution: 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1380 N. Calhoun St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Janie Gibbs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife William H. Gibbs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 16, 1908

8. AGE: Years	Months	Days	If less than one day
45	11	7	hr. min.

9. Birthplace Standville, Virginia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Tibbs
13. Birthplace Va.

MOTHER
14. Maiden Name Cora Hays
15. Birthplace Va.

16 (a) Informant Mr. William H. Gibbs
(b) Address 1380 N. Calhoun St.

17 (a) Burial (b) Date thereof 1-27-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem.
Location Anne Arundel Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) JAN 27 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH January 23, 1948, at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 16 1947, to 1-23 1948.
and that I last saw h alive on 19

Immediate cause of death	Duration
Acute Coronary occlusion	
Due to Myocardial degeneration	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank [illegible] M. D.
Address 1543 Penna Ave Date signed 1/28/48

V S 150

X

NOTE—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59455 BC: d 8-0211 JL- 116890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

G59455 Registered No.

Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly. PENCIL PROHIBITED, WITH UNFADING INK.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave. 2-3

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2048 Fountain St - 31
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Janice Leah Kaniecki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 1, 1948

8. AGE: Years | Months | Days 26 25 | If less than one day ... hr. ... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George James Kaniecki

13. Birthplace Md.

MOTHER 14. Maiden Name Sarah Leah Stone

15. Birthplace Md.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-27-48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ ST STANISLAUS

Location BALTO Md.

18 (a) Funeral director George A Weber

(b) Address 706 S Bond St

19 (a) JAN 27 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26 1948, at 7.55A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 25 1948, to Jan. 26 1948, and that I last saw her alive on Jan. 26 1948.

Immediate cause of death Atelectasis — Duration 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: atelectasis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Harold H Becker

Address Balto City Hosp Date signed 1/25/48
M. D.

VS 150

X

C59456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 51B

Registered No. C59456

Type or print with UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 N. Port St.
(c) Hospital or institution: T.V.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 N. Port St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles W. Sunderland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Margaret L. Sunderland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17-1884

8. AGE: Years	Months	Days	If less than one day
63	9	7	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Truck Driver
11. Industry or business

FATHER
12. Name Beverly Sunderland
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Sally Espey
15. Birthplace Balto. Md.

16 (a) Informant Mary B. Schaech
(b) Address 504 N. Port St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 20-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location O'Donnell St.

18 (a) Funeral director John L. Miller
(b) Address 2334 Jefferson St.

19 JAN 27 1948 (Date rec'd by Registrar) Lester Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24 1948, at 5:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1945 to Jan 24 1948 and that I last saw him alive on Jan 23 1948.

Immediate cause of death Carcinoma Prostate — Duration 3 yrs.
Due to Hydronephrosis, Pyelonephritis & Pyelitis Left — 6 mos.
Due to Uremia
Other Conditions Marked Emaciation

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. S. Keyser M.D.
Address 156 N. Western Ave. Date signed 1/28/48

VS 150

C59457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

GM. 116021 / 186a

Registered No. C59157

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) Most of Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4217 Shamrock Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Cornelia Agnes Glenn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24 1865

8. AGE: Years	Months	Days	If less than one day
82	2	1	hr. min.

9. Birthplace VA. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Matthew Miller
13. Birthplace Ireland

MOTHER
14. Maiden Name Ann Rebecca Moore
15. Birthplace VA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 27 48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave.

18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St.

19 JAN 27 1948 (Date rec'd by registrar) Hattie Fox Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-25-1948, at 4.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-19 1947, to Jan. 25 1948, and that I last saw her alive on Jan. 25-1948.

	Duration
Immediate cause of death Acute Peritonitis	1 day.
Due to Acute enterocolitis & dehydration	3 days
Due to	
Other Conditions Fracture of pelvis (Include pregnancy within 3 months of death)	1 month

Date of operation 1-24-48.
Major findings of operation: ruptured obstruction
of autopsy: Peritonitis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 26/2
(a) Accident, ~~suicide, or homicide~~ Accident ?
(b) Date of occurrence 12-18-48 at ? M
(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? No
(e) Means of injury Pt. fell. (Slipped and fell to floor)

23. Signature Geo E [illegible] M. D.
Address 4940 Eastern Ave. Date signed 1-26-48

To be approved by Medical Examiner Wm. H. Kaemmer Jr., M.D.
Howard J. Mueller, M.D.

VS 150

CAUTION—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59458

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G59458 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3025 Windsor Ave
(c) Hospital or institution: Windsor Nursing Home 27-15
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) --

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2407 Everton Rd. (If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME JOHN W. LATSON (III)

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Elizebeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1864

8. AGE: Years	Months	Days	If less than one day
84	0	23	hr. min.

9. Birthplace ~~New York City~~ Yonkers N Y (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Retired

FATHER
12. Name John W. Latson Jr.
13. Birthplace NYC

MOTHER
14. Maiden Name Mary A. ~~Strong~~ Young
15. Birthplace NYC

16 (a) Informant Mrs. Helen K Russell
(b) Address 814 E. Belvedere, Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/48 (month) (day) (year)
(c) Cemetery or ~~cremation~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director W. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves; Balto., Md.

19 (a) JAN 27 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24, 1948, at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/27 1947 to 1/24 1948 and that I last saw him alive on 1/24 1948.

Immediate cause of death	Duration
Myocardial insufficiency	1 day
Due to Arteriosclerotic Heart disease	6 yrs +
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert A. Reiter M. D.
Address 3400 Windsor Ave Date signed 1/26/48

G59459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G59459 Registered No.

GM. 106639

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Year
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Schafer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14 1880 ?

8. AGE: Years	Months	Days	If less than one day
67 ?	11	11	hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation Blacksmith (Retired)

11. Industry or business

FATHER
12. Name John Casper Schafer
13. Birthplace MD.

MOTHER
14. Maiden Name Pricilla
15. Birthplace MD.

16 (a) Informant Records B lto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/48 (month) (day) (year)
(c) Cemetery or crematory London Pk
Location Balto. Md.

18 (a) Funeral director Wm J Tickner & Sons
(b) Address North & Pitts Sts Balto Md

19 JAN 27 1948 (Date rec'd by Registrar) (b) Huntington Nolte, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-25-48 1948, at 2.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12 - 5 - 1946, to 1 - 25 - 1948, and that I last saw him alive on Jan. 25 - 1948.

Immediate cause of death ? Coronary occlusion

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none done

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. T. Bamford M. D.
Address Balt. City Hosp Date signed 1-26-48

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

659460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

659460 Registered No.

TYPE OR PRINT PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 433 N. Fremont Ave
(c) Hospital or institution: 17-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 433 N. Fremont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Price

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W.

6 (b) Name of husband or wife Ruben Price
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April-1880

8. AGE: Years	Months	Days	If less than one day
67	9		hr. min.

9. Birthplace Richmond Va
(Town, county, and state)
10. Usual Occupation domestic
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " " "

MOTHER
14. Maiden Name Unknown
15. Birthplace " " "

16 (a) Informant Samuel Sullivan Jr.
(b) Address 117 N. Carrollton Ave

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 1-28-48 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Balto. Co.

18 (a) Funeral director Samuel W. Sullivan Jr.
(b) Address 1011 N. Arlington Ave.

19 (a) 27 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25 1948, at 5 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1947 to Jany 25 1948
and that I last saw h[illegible] alive on Jany 24 1948

Immediate cause of death Coronary Thrombosis — Duration
Due to Arteriosclerosis
Due to Hypertension
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Haight M. D.
Address 601 N. Arlington Ave Date signed 1/27/48

X

G59461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

GM. 115402 1110a

Registered No. G59461

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Months
(e) Length of stay in Baltimore (yrs., mos., or days) 23 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 404 Green ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Abraham ~~Aronsky~~ ARONSKY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ? ? ?

8. AGE: Years	Months	Days	If less than one day
75 ?			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? Leon
13. Birthplace ? Russia

MOTHER
14. Maiden Name ? Not Known
15. Birthplace ? Russia.

16 (a) Informant Records Balto. Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28-48 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Rogers Ave

18 (a) Funeral director John Sens Inc
(b) Address 2100 Eutaw Pl

19 JAN 27 1948 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-26-1948, at 10.00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-21-1947, to 1-26-1948, and that I last saw him alive on 1-26-1948.

Immediate cause of death Respiratory Failure — Duration 2 hrs.

Due to Chronic emphysema — 10 yrs.

Due to

Other Conditions Bronchiectasis — 10 mos.

(Include pregnancy within 3 months of death)

Date of operation 12-2-1947

Major findings of operation: ~~cancer~~ emphysema

of autopsy: emphysema & bronchiectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gordon Craft

Address Balt. City Hosp. Date signed 1/27/48 M. D.

VS 150

TO INSURE PROMPT FILING, WITH UNFADING INK. Every item of information should be carefully supplied. Type or write plainly. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

G59462

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH V10f

G59462 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The following item of information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 19.3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name town)
(d) Street No. 1528 Hollins St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Asner, Walter

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1904

8. AGE: Years	Months	Days	If less than one day
44			hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Moses
13. Birthplace Russia

MOTHER
14. Maiden Name Annie
15. Birthplace Russia

16 (a) Informant Robert asner
(b) Address 2149 Orkeny ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-27-48 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Boulevard

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (Date received by local registrar) JAN 27 1948 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 Jan 19 48 at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 Jan 19 48 to 25 Jan 19 48, and that I last saw h[illegible] alive on 25 Jan 19 48.

Immediate cause of death	Duration
Pneumonia, RUL, RML, RLL, LLL	2 wks
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Manuel D. Dana M. D.
Address Sinai Hosp Date signed 1-25-48

VS 150

G59463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G59463 Registered No.

The information should be carefully supplied. The ... especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6. Monument St
(c) Hospital or institution Sinai Hospital 6-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 14 N. Collington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MRS ROSE GOLDSTEIN

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Abraham Isaac -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 59 Months: Days: If less than one day: hr. min.

9. Birthplace: Russia (Town, county and state)
10. Usual Occupation: Hunter's wife
11. Industry or business

FATHER
12. Name: Hyman -
13. Birthplace: Russia

MOTHER
14. Maiden Name: Celia -
15. Birthplace: Russia

16 (a) Informant: Minnie Goldstein (Sister)
(b) Address: 14 N. Collington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-27-48 (month) (day) (year)
(c) Cemetery or crematory: Druid Hill Ave.
Location:

18 (a) Funeral director: Jack Levine Inc.
(b) Address: 400 Eutaw Place

19 JAN 27 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-25- 1948 at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25 1948 to 1-25 1948, and that I last saw her alive on 1-25 1948

Immediate cause of death: Cerebral Hemorrhage — Duration:
Due to: Essential Hypertension and generalized
Due to: arterio - sclerosis
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation: none
Major findings of operation: none
of autopsy: not performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Allan Y. Wolinsky M.D.
Address: Sinai Hosp. Date signed 1-25-48

VS 190

X

G59464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G59464

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2819 Oakford Ave
(c) Hospital or institution: 27-16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2819 Oakford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mollie Gershman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Benjamin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER
12. Name Israel
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Mrs. Harry Crystal
(b) Address 2926 Glenmore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-27-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men's Location Wingate Mill Rd.

18 (a) Funeral director Jack Levin Sons
(b) Address 2100 Eutaw Place

19 (a) JAN 27 1948 (Date rec'd by registrar) (b) Huntington Williams Mortician Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 1948, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940 to Jan 26 1948, and that I last saw her alive on Jan 26 1948.

Immediate cause of death	Duration
Coronary Thrombosis	Instant
Due to: Arteriosclerosis	10 yrs
Due to	
Other Conditions Gall bladder disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David N. Kolman M.D.
Address 3700 Park Heights Ave Date signed Jan 27 1948

V S 150

IMPORTANT. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G59465 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 322 Park Ave
(c) Hospital or institution: 4-1
Place of Business
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 332 Park Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Fong Lung Sing----------Fong Quong Shang

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: M

5. Color or race: Yellow

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Gee Shee&Bettha Tanzer

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan-10-1883

8. AGE: Years 65 | Months 0 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Colusa Co. United States
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business: Restaurant

FATHER
12. Name: Fong Wing
13. Birthplace: Not Known

MOTHER
14. Maiden Name: Tom See
15. Birthplace: Not Known

16 (a) Informant: Fong Bing Thin (son)
(b) Address: 27 S. 18th. St., Phila. Penna.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Jan-27-48 (month) (day) (year)
(c) Cemetery or crematory: Greenmount
Location: Baltimore, Maryland

18 (a) Funeral director: Stewart & Mowen Company
(b) Address: 108 W. North Ave., City #1

19 (a) JAN 27 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23 1948 at 2 15 P M

21. I certify that I took charge of the remains described above, held an Aug Exam. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Helfrich M.D.
Medical Examiner.
Date signed Jan 23, 1948

Accurate age is especially important. Physicians: please write the causes of death clearly and legibly. The name, residence or information should be carefully supplied.

G59466

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G59466
Registered No.

Please write plainly in ink. Information should be carefully supplied. The accuracy of this certificate is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3500 Hillen Rd 11-3
(c) Hospital or institution: Ashburton Home (Mrs. Shriver's)
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. all Baltimore addresses
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE AGNES MOLESWORTH

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife: Edward M. Molesworth

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) December-10-1862

8. AGE: Years 85 | Months 1 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business: None

FATHER
12. Name: John H. DeMuth
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Sarah McKee
15 Birthplace: Baltimore, Maryland

16 (a) Informant: Mr. Charles S. DeMuth (brother)
(b) Address: 222 W. Madison Street, City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan- -1948 (month) (day) (year)
(c) Cemetery or crematory: Pine Grove
Location: Mt. Airy, Carroll Co. Md.

18 (a) Funeral director: Stewart & Mowen Company
(b) Address: 108 W. North Ave., City.

19 (a) JAN 27 1948 (Date rec'd by registrar) (b) Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25/48 19 ____, at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1947 to ____ 19 ____, and that I last saw h-r alive on Jan 2 1948.

Immediate cause of death	Duration
Myocarditis	about 3 mo.
Due to advanced arterio sclerosis	?
Due to	
Other Conditions Hypertension	?

(Include pregnancy within 3 months of death)

Date of operation ____

Major findings of operation: ____

of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles S Rublatt M. D.
Address 220 Garrison Blvd Date signed Jan 26/48

VS 150

G59467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G59467
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ✓
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: The Seton Institute 28-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6420 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Mary Clare McGowan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-18-1872

8. AGE: Years	Months	Days	If less than one day
75	7	8	hr. min.

9. Birthplace Ireland
(Town, county, and state)
10. Usual Occupation Sister of Charity
11. Industry or business

MOTHER | FATHER
12. Name John McGowan
13. Birthplace Ireland
14. Maiden Name Rose Reilly McGowan
15. Birthplace Ireland

16 (a) Informant The Seton Institute
(b) Address 6420 Reisterstown Rd., Balto. 15, Md.

17 (a) Burial (b) Date thereof 1- -48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Seton Institute
Location Reisterstown Road

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (R. F. WOODS SUC.) 100 N. NORTH AVENUE

19 JAN 27 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 1948, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death Reynaud's Disease — Duration 3 weeks

Due to

Due to

Other Conditions General Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dominic J. Blasi M. D.
Address 33 W. Mulberry St. Date signed

VS 150

99

C59468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

C59468

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 145 W. Lafayette Ave.
(c) Hospital or institution: 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 145 W. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rear Admiral Yates Stirling, Jr., Sterling U. S. N., Retired

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Adelaide Egbert
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) April 30, 1872

8. AGE: Years	Months	Days	If less than one day
75	8	27	hr. min.

9. Birthplace Vallejo, California
(Town, county, and state)
10. Usual Occupation U. S. Naval Officer,
11. Industry or business retired

MOTHER / FATHER
12. Name Rear Admiral Yates Stirling
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ellen Haley
15. Birthplace Florida

16 (a) Informant Capt. Yates Stirling, III, U.S.N. retired
(b) Address Norfolk, Va.

17 (a) Cremation (b) Date thereof 1/27/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frdk. Ave. Balto. Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) JAN 27 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 11, 1946, to Jan 27, 1948, and that I last saw him alive on Jan. 25 1948.

Immediate cause of death	Duration
Uraemia	1 week
Due to Arteriosclerotic cardiovascular renal disease	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Tillen Howard M. D.
Address 12 E. Eager St. Date signed Jan. 27, 48

VS 150

G59469

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

96

Registered No. G59469

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard and Greene
(c) Hospital or institution: Univ. Hospital 21-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Ryan St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Florence Sullivan (FLORENCE V. SULLIVAN)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John C. Sullivan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18 1905

8. AGE: Years 42 | Months 6 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Howard V. Nash
13. Birthplace Balto Md

MOTHER
14. Maiden Name Florence Caughey
15. Birthplace Balto Md

16 (a) Informant Nellie Watkins
(b) Address 1841 Ramsay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 27-1948 (month) (day) (year)
(c) Cemetery or crematory Bloy Haven
Location Balto Co Md

18 (a) Funeral director Pott C & B M Walter
(b) Address Pratt & Fulton Sts

19 JAN 27 1948 (Date rec'd by registrar) (By) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/23/48 19 , at 10:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15/48 19 , to 1/23/48 19 , and that I last saw h e alive on 1/22/48 19 .

Immediate cause of death Respiratory failure
Duration
Due to Lob. bronchial pneumonia
Due to
Other Conditions none
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Lob. bronchial pneumonia
Contributory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. H. Powell Jr. M. D.
Address Univ Hospital Date signed 1/23/48

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

G59470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G59470 ✓ Registered No.

BC-C 9145#

182a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 922 Brevard Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charleen STERRETT

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/16/47

8. AGE: Years	Months	Days	If less than one day
	3	9	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Chas Sterrett
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Bernice Robinson
15. Birthplace N. Carolina

16 (a) Informant Chas. Sterrett
(b) Address 922 Brevard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Wes. H. Nelson
(b) Address 1303 Pennsylvania Ave

JAN 27 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 1948, at 9:15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Mechanical suffocation

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-25-48 at 11/2 A.M.
(b) Where did injury occur? 922 Brevard Street
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury Suffocation by bedclothes

23. Signature Geo. H. Merrill M.D.
Medical Examiner.
Date signed 1/26/48

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G59471

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92a

G59471
Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The ... Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyamn Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital 2-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 24 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 509 Archer St., Baltimore, Md. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Mitchell, Isaac Frank

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW II	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	c	married (Sibley)

6 (b) Name of husband or wife Esther Mitchell
6 (c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr) Nov. 5, 1922

8. AGE: Years	Months	Days	If less than one day
25	2	21	hr. min.

9. Birthplace Charlotte, N. C. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John Mitchell
13. Birthplace Charlotte, N. C.

MOTHER
14. Maiden Name Gertrude Caldwell
15 Birthplace Charlotte, N. C.

16 (a) Informant Records
(b) Address U S Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 29, 1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) JAN 27 1948 (Date rec'd by registrar) (b) Huntington Williams Mortician

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24, 1948 9, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 7, 1948, to Jan. 24 1948, and that I last saw him alive on Jan. 24, 1948.

Immediate cause of death	Duration
Rheumatic endocarditis with aortic stenosis	UNKNOWN
Due to	
Due to	
Other Conditions Pulmonary infarcts multiple (Include pregnancy within 3 months of death)	3 wks.

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
Address U S Marine Hospital, Baltimore, Md. Date signed Jan. 26, 1948

VS 159

G59472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

307

G59472
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17-1
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 714 Wilmer Court.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PEARL CUNNINGHAM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Jerry Cunningham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1890

8. AGE: Years 57 | Months 5 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Milligan Florida
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Silas Jackson
13. Birthplace Florida

MOTHER
14. Maiden Name Patsy ?
15. Birthplace Florida

16 (a) Informant Rosa Haines
(b) Address 1401 Edmondson Ave.

17 (a) Burial (b) Date thereof Jan. 27, 1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory W. H. Odenheimer Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

JAN 27 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22, 1948, at 1.05 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Syphilitic aortitis
Myocardial Degeneration
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Rogers M.D.
Medical Examiner
Date signed 1-22-48

Correctness of every item of information should be carefully supplied. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

G59473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

497

G59473
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk, Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 Baltimore Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FLORENCE TYLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	White	Married.

6 (b) Name of husband or wife HARRY L. TYLER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 7, 1888

8. AGE: Years	Months	Days	If less than one day
60	0	19	hr. min.

9. Birthplace Delaware (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Darling
13. Birthplace Delaware

MOTHER
14. Maiden Name Ida Hill
15. Birthplace Delaware

16 (a) Informant Harry L. Tyler
(b) Address 114 Baltimore Ave., Dundalk

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 28, 1948 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Washington Blvd, Elkridge, Md.

18 (a) Funeral director Roland L. Fyffe
(b) Address 2112 Dundalk Ave.

19 (a) JAN 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-26-48 19 , at 3 50 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1947 to 1-26 1948, and that I last saw h alive on 1-26 1948.

Immediate cause of death	Duration
Carcinoma of vulva c metastasis to brain.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gilbert M. Courage
Address 6226 Everall Ave. Date signed 1-26-48 (M. D.)

VS 150

G59474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59474 937 Dr. Chilly

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1102 Stoddard Court
(c) Hospital or institution: McCulloh Homes 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1452 N. Carey Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: CHARLES CHRISTOPHER

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-8388

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Rosa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1887

8. AGE: Years 60 | Months 3 | Days 12 | If less than one day hr. min.

9. Birthplace Northumberland Co. Va. (Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER: 12. Name Charles Christopher
13. Birthplace Northumberland Co. Va.

MOTHER: 14. Maiden Name Sophronia Kemp
15. Birthplace Northumberland Co. Va.

16 (a) Informant William Christopher
(b) Address 1224 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 27 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave

19 JAN 27 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1948, at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 1948, to Jan 24 1948, and that I last saw him alive on 19

Immediate cause of death	Duration
Myocardial degeneration	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Lindsay M. D.
Address 1343 Fremont Ave Date signed 1/26/47

VS 150

G59475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G59475 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland 28-4

(b) Street address 2025 W. Fayette St.

(c) Hospital or institution: Bon Secours Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 44 da.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4706 Amberly St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Louise R. Kuhlemann

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Samuel Kuhlemann | 6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Jan. 13, 1864

8. AGE: Years: 84 | Months: — | Days: 13 | If less than one day: ____ hr. ____ min.

9. Birthplace: Woodstock, Howard Co. Md. (Town, county, and state)

10. Usual Occupation: Seamstress

11. Industry or business: Retired

FATHER 12. Name: Peter Miller

13. Birthplace: Germany

MOTHER 14. Maiden Name: Nancy Casey

15. Birthplace: Howard Co. Md.

16 (a) Informant: Mrs. Margaret P. Burke

(b) Address: 6405 Frederick Ave. Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan. 28/48 (month) (day) (year)

(c) Cemetery or crematory: St. Paul's Cem. Location: Violetville, Md.

18 (a) Funeral director: Easton Sons

(b) Address: 608 Frederick Ave. Catonsville

JAN 27 1948 (Date rec'd by registrar) (b) Huntington Willis (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 25 1948 at 855 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12 1947 to Jan. 25 1948 and that I last saw h RV alive on Jan. 25 1948.

Immediate cause of death: Gas gangrene infection — Duration: 12 hours

Due to:

Due to:

Other Conditions: Diabetes mellitus, Arteriosclerosis — 10 years?

(Include pregnancy within 3 months of death)

Date of operation: Jan. 21, 1948

Major findings of operation: diabetes gangrene

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ____ at ____ M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: Walter B. Sanger,

Address: Bon Secours Hospital Date signed: M. 1 D. 25 48

VS 150

G59476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G59476

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Sorrento Rd 19-2
(c) Hospital or institution: Colonial Nursing & Emerg. Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1601 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth C. Hammond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
F	W	

6 (b) Name of husband or wife Harry Hammond
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1874

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name	? McAdams
FATHER 13. Birthplace	Maryland
MOTHER 14. Maiden Name	?
MOTHER 15. Birthplace	Maryland

16 (a) Informant Son-Edward J. Connolly
(b) Address 428 S. Bond St.

17 (a) Burial (b) Date thereof 1-28-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathy
Location Edmondson Ave

18 (a) Funeral director Frank Della Vale
(b) Address 152 N. Morley St.

1948 JAN 27 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/25 1948, at 6 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1947 to 1/25 1948 and that I last saw h[er] alive on 1/25 1948

Immediate cause of death Generalized Carcinomatosis — Duration 6 months

Due to L. A. Tumor

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carl L. Royer

Address 142 Huntsman Place Date signed 1/27/48

VS 150

G59477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G59477

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 8-6
(b) Street address St. Joseph's Hospital
(c) Hospital or institution 1411 Blk. N. Caroline St.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1509 N Dallas St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta Washington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Col

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 17 - 1889

8. AGE: Years 59 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name William Harrison
13. Birthplace Va

MOTHER
14. Maiden Name Catherine Lancaster
15. Birthplace Va

16 (a) Informant Catherine Jones
(b) Address 1509 N Dallas St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A. A. Co

18 (a) Funeral director Payne Sanders
(b) Address 1412 E. Preston St

19 JAN 27 1948 (Date received by registrar) (Signature of registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Jan. 1948, at 5:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to Hypertensive Cardio-Vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm H Hammer Jr. M.D. Medical Examiner.
Date signed 23 Jan. 1948

VS 151

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G59478

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Woodlawn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5800 Windsor Mill Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LENA T. BORGMANN

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or ~~wife~~ William F. Borgmann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26, 1872

8. AGE: Years 75 | Months 10 | Days 30 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Frederick Bartling
13. Birthplace Germany

MOTHER
14. Maiden Name Ellen A. Best
15. Birthplace Germany

16 (a) Informant Milton W. Borgmann
(b) Address 2139 Lorraine Ave., Woodlawn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director C. Howard Strong
(b) Address 3207 W. North Ave.,
(c) JAN 27 1948 (Date received by registrar) Burlington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25 1948 at 10:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-8 1948 to 1-25 1948 and that I last saw h ER alive on 1-25 1948

Immediate cause of death Respiratory failure

Due to Cerebral Vascular accident

Due to

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Morrow Jr. M. D.
Address Md. Gen. Hosp. Date signed 1-25-48

VS 150

83a

G59479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G59479 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St. Joseph's Hospital 6-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 18 N. Linwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin P Trawinski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Lillian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/21/1905

8. AGE: Years	Months	Days	If less than one day
42 43	8	3	hr. min.

9. Birthplace Baltimore, Md
(Town, county and state)

10. Usual Occupation Upholsterer

11. Industry or business

FATHER 12. Name John Trawinski
13. Birthplace Poland

MOTHER 14. Maiden Name Marzalek
15. Birthplace Poland

16 (a) Informant Martin P Trawinski
(b) Address 18 N Linwood Ave

17 (a) Burial (b) Date thereof Jan 28/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Germantown Pike

18 (a) Funeral director John E. Rodgers
(b) Address 3000 E. Baltimore St

19 (a) JAN 27 1948 (b) Huntington Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/24 1948, at 9 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/24 1948, to 1/24 1948, and that I last saw him alive on 1/24 1948.

Immediate cause of death	Duration
Cerebral vascular accident	
Due to Hypertensive cardiovascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E May M. D.
Address 1400 N Caroline St Date signed 1/24/48

V S 150

Hoelzer

G59480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G59480

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1200 Valley St.

(c) Hospital or institution: Home for the Aged Poor

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-6

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2728 Mooker St., (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Haelzer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	W.

6 (b) Name of husband or wife Jacob Haelzer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1864

8. AGE: Years	Months	Days	If less than one day
83	11		hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER 12. Name Bartholomew Bradley

13. Birthplace Ireland

MOTHER 14. Maiden Name Isabelle Kelly

15. Birthplace Ireland

16 (a) Informant Ellen Sisler 2 Fell Pos

(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/49 (month) (day) (year)

(c) Cemetery or crematory St Mary's Govans

Location Homeland Ave

18 (a) Funeral director J. J. Doherty & Son

(b) Address 1208 Light St.

19 (a) JAN 27 1949 (Date of registration) (b) Tunstall for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1949, at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948, to Jan 24 1948, and that I last saw her alive on Jan 24 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to	
Due to	
Other Conditions Arterio-Sclerosis	5 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. Gill Hall M. D.

Address 1631 E. North Ave Date signed 1/26/49

VS 150

X

G59481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G59481

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Baltimore City Hosp.
(c) Hospital or institution: 26-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 900 S. Conkling St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: William E. McGee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Ethelreda McGee
6 (c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): Feb. 25, 1907

8. AGE: Years	Months	Days	If less than one day
40	11	0	____ hr. ____ min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual Occupation: Business Agent
11. Industry or business: Amer. Fed. of Labor.

FATHER
12. Name: Thomas F. McGee
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Daisy Mae Dix
15. Birthplace: Baltimore, Md.

16 (a) Informant: Ethelreda McGee (Wife)
(b) Address: 900 S. Conkling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-29-48. (month) (day) (year)
(c) Cemetery or crematory: Sacred Heart Cemetery
Location: 4701 German Hill Rd.

18 (a) Funeral director: Charles S. Zeiler.
(b) Address: 901 S. Conkling St.

19 (a) JAN 27 1948 (Date Rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 25 Jan. 1948 at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Occlusion

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: Wm. H. Kammerer M.D.
(Medical Examiner.)
Date signed: 26 Jan. 1948

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X

PRINT WITH INDELIBLE INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C59482

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

Registered No. C59482

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hosp. 7E-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1403 S. Highland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Charles Schubert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1913.

8. AGE: Years	Months	Days	If less than one day
35	0	4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Deck-Hand

11. Industry or business Eastern Transportation

FATHER
12. Name Charles Schubert
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Alverta Burke
15. Birthplace Baltimore, Md.

16 (a) Informant Charles Schubert (Father)
(b) Address 1403 S.Highland Ave.

17 (a) Burial (b) Date thereof 1-28-48.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location 7225 Eastern Ave. Rd.

18 (a) Funeral director Charles L. Zeiler
(b) Address 901 S. Conkling St.

19 (a) JAN 27 1948 (b) [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/25 1948, at 6 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull & intra cranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/23 at 7:45 P. M.
(b) Where did injury occur? Elliott & Lombard Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by fist

23. Signature Emil L. Kugel M.D.
Medical Examiner.
Date signed 1/25/48

VS 191

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C59483 JORIO

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. C59483

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 75-4
(b) Street address
(c) Hospital or institution: Balt. City Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 501 Baltic Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel E Jorio

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Jos. Jorio
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/31/1910

8. AGE: Years	Months	Days	If less than one day
37 38	11	25	hr. min.

9. Birthplace Jan 31 - 1910 (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name	Wm Mayson
13. Birthplace	Berkley W. Va
MOTHER 14. Maiden Name	Priscilla Tyre
15. Birthplace	W. Va

16 (a) Informant Mr. Jos Jorio
(b) Address 501 Baltic Ave-25
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 28-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Gor Patapsco Highway
18 (a) Funeral director Milton Schellenberg
(b) Address 3914 Hanover St
19 JAN 27 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/25 1948, at 1 00 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured Aorta (Thoracic)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/24/48 at 11 00 P. M. 25/4
(b) Where did injury occur? Home
(c) Did injury occur at home, on farm, industrial place, in public place? 501 Baltic Ave While at work? No
(d) Means of injury Fall in bath room

23. Signature [signature] M.D.
Medical Examiner.
Date signed 1-5-48

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G59484

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G59484

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2214
(c) Hospital or institution: Hosp. Women of Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4320 Roland Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Katherine Baker Houston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	divorced widowed

6 (b) Name of husband or wife William Hamilton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10 1871

8. AGE: Years	Months	Days	If less than one day
? 76	7	16	hr. min.

9. Birthplace Charlottesville Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Samuel Baker
13. Birthplace Virginia

MOTHER
14. Maiden Name Fannie McArthur
15. Birthplace Virginia

16 (a) Informant Mrs Crouse
(b) Address 614 Tunnel St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 28 1948 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Darlington
Location Darlington Md

18 (a) Funeral director Henry McKenrick & Sons
(b) Address McCulloh & Orchard Sts

19 (a) JAN 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 26 - 1948, at 8 55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan - 23 - 1948, to Jan 26 1948, and that I last saw h er alive on Jan - 26 - 1948

Immediate cause of death	Duration
Myocardial Infarction	
Due to Medistinal Emphysema	
Due to Rupture of pleural adhesions	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Myocardial Infarction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George H. Lecklessner M. D.
Address Hosp. Women Md Date signed 1-26-48

VS 150

G59485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G59485

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1602 E. Fort Ave
(c) Hospital or institution: 24-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 E. Fort Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George J. Bohle

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-01-0152

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary Bohle
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) 3-3-1893

8. AGE: Years	Months	Days	If less than one day
54	10	17	20 hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Shipyard Worker
11. Industry or business

FATHER
12. Name Otto Bohle
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Thayler
15. Birthplace Baltimore

16 (a) Informant Mary Bohle
(b) Address 1602 E. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28-48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A.A. Co.

18 (a) Funeral director Charles F. Duff
(b) Address 1501 E. Fort Ave

19 (a) JAN 27 1948 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1948 at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1947 to Jan 23 1948 and that I last saw h[illegible] alive on Jan 22 1948.

Immediate cause of death	Duration
(a) Coronary Thrombosis	
Due to	
Due to	
Other Conditions Diabetes Endo-Carditis - Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
of autopsy: —

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Schreuer
Address 337 S. Charles St. Date signed 1/26/48

VS 150

94a

659486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

Registered No. 659486

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 8-2
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 Vine Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Peter Lewis

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 218-09-6050

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Thelma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/ 10/1900

8. AGE: Years 47 | Months 7 | Days 13 | If less than one day hr. min.

9. Birthplace Orange, Va. (Town, county, and state)

10. Usual Occupation Truck Helper

11. Industry or business

FATHER
12. Name George Lewis
13. Birthplace Orange, Va.

MOTHER
14. Maiden Name Maggie
15. Birthplace Va.

16 (a) Informant Elgia Tilghman (Sister in
(b) Address 102 Sarahann St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (a) JAN 27 1948 (Date rec'd by Registrar) (b) Burrington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23 1948, at 9 30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Stab wound of Heart.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-23-48 at 9:45 P M.
(b) Where did injury occur? 1006 Vine Court
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Edged Instrument

23. Signature Emil R. Kayer M.D. Medical Examiner
Date signed 1-24-48

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C59487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47a

Registered No. C59487

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 917 Hillen St
(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) All Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 917 Hillen St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Simpson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-24

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Patterman Stewart
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Laura Forman
15. Birthplace Baltimore Md

16 (a) Informant Grace Simpson
(b) Address 917 Hillen St

17 (a) Burial (b) Date thereof Jan 30-1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem.
Location Baltimore Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1035 Blanstty ave

19 (a) 1-27-1948 (Huntington Williams, M.D.) Registrar
(Date filed by Registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/25 1948, at 3:45 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner
Date signed 1-27-48

The information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. G59488

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1924 Gough Street
(c) Hospital or institution: 2-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1924 Gough Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ANDREW-HENRY POSKO, also known as Pasko-Paszko

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-3173

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Julianna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 19, 1881

8. AGE: Years	Months	Days	If less than one day
66	2	7	hr. min.

9. Birthplace Wisniowa, Poland
(Town, county, and state)
10. Usual Occupation Iron Moulder
11. Industry or business Iron Foundry

FATHER
12. Name Waclaw Pasko
13. Birthplace Wisniowa, Poland

MOTHER
14. Maiden Name Catherine Cial
15. Birthplace Wisniowa, Poland

16 (a) Informant Miss Agnes Posko
(b) Address 1924 Gough Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/48 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. F. Sadowski & Sons
(b) Address 1808 Eastern Aveme

19 (a) JAN 27 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26 1948, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 24 to Jan. 26 1948
and that I last saw him alive on Jan. 26 1948

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 days

Due to: Malignant Tubular Hypertrophic Arteriosclerosis — Duration: 6 mos. 4 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis J. Peeples M. D.
Address 700 E. Pratt St. Date signed 1-27-48

VS 150

C59489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered C59489

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 Caroline

(c) Hospital or institution: St Joseph's Hospital 9-9

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1606 Lamont Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Henry Trentler

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Bertha Silberzahn

6 (c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.) 10/24/1866 10/14/1866

8. AGE: Years 81 | Months 3 | Days 11 | If less than one day ########## hr. ########## min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Pipe Moulder (Foundry)

FATHER 12. Name Trentler

FATHER 13. Birthplace

MOTHER 14. Maiden Name

MOTHER 15. Birthplace

16 (a) Informant Mr. Lawrence Trentler (Son)

(b) Address 1606 Lamont Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/48 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location E. North Avenue, Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.

(b) Address 1735 Harford Avenue

19 (a) JAN 27 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/25/48 19 , at 1 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/24/48 19 , to 1/25/48 19 , and that I last saw h- alive on 1/25/48 19 .

Immediate cause of death: Cardio-Respiratory failure

Due to: Arteriosclerosis

Due to:

Other Conditions: Hematuria - Anemia - Malnutrition

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Ishtlia A Bailey M. D.

Address St Joseph's Hosp. Date signed 1/26/48

V S 150

X

59290 296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

128

Registered No. 59490

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 601 N. Broadway 10-2

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County City

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 608 Webb Court (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Joseph Gray (Joseph W. Gray)

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Loretta McGonigle

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) 12-29-05

8. AGE: Years	Months	Days	If less than one day
42	0	26	##### min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name James Gray

13. Birthplace Md

MOTHER 14. Maiden Name Ellen Parr

15. Birthplace Md

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29th/48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road, Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.

(b) Address 1735 Harford Avenue

19 (a) JAN 27 1948 (Date rec'd by registrar) (b) Hermann for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1948, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1948 to Jan 25 1948; that I last saw him alive on Jan 25 1948.

Immediate cause of death: Obstructive jaundice — Duration: 2 wks

Due to: Chronic pancreatitis — 6+ yrs

Due to:

Other Conditions: Pancreatic abscesses

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Victor A. McKusick M.D.

Address Johns Hopkins Hosp. Date signed 1/25/48

VS 150

G59491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95a

Register G59491

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1167 W. HAMBURG ST.
(c) Hospital or institution: 21-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1167 W. HAMBURG ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EMILE THOMAS FOREACRE

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 216-09-1176

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ELSIE V. FOREACRE
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) JULY 20, 1889

8. AGE: Years	Months	Days	If less than one day
58	6	5	hr. min.

9. Birthplace BALTIMORE (Town, county, and state)
10. Usual Occupation SHEET METALWORKER
11. Industry or business MD DRY DOCK.

FATHER
12. Name THOMAS T. FOREACRE
13. Birthplace VA.

MOTHER
14. Maiden Name ANNIE SCHELL
15. Birthplace BALTO. MD.

16 (a) Informant ELSIE V. FOREACRE
(b) Address 1167 W. HAMBURG ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN 28 48 (month) (day) (year)
(c) Cemetery or crematory LOUDEN PARK CEM.
Location FREDERICK AVE.

18 (a) Funeral director AMBROSE INC
(b) Address 414 N. Franklintown Rd

19 (a) JAN 27 1948 (Date rec'd by registrar) (b) Huntington & Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19th 1948 to Jan 25th 1948 and that I last saw h[illegible] alive on Jan 25th 1948

Immediate cause of death	Duration
Auricular Fibrillation	4 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Kates M. D.
Address 517 Acom St Date signed 1-26-48

VS 190

G59492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G59492

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St.
(c) Hospital or institution: Good Samaritan Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18da
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1122 Somerset St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Jones

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	married

6 (b) Name of husband or wife Alice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-27 1875

8. AGE: Years	Months	Days	If less than one day
72	6	21	hr. min.

9. Birthplace Alabama. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name James Jones
13. Birthplace ala.

MOTHER
14. Maiden Name Mary Gadd
15. Birthplace Ala.

16 (a) Informant Alice Jones
(b) Address 1122 Somerset St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave.,

19 (a) (Registrar's signature) JAN 27 1948 (b) Washington Hollingsworth Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1947 to Jan 18 1948 and that I last saw him alive on Jan 14 1948

Immediate cause of death	Duration
Cardiac Renal disease	
Due to	
Due to	
Other Conditions Uremia Convulsions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theo K. Hansemann Jr. M.D.
Address 27 N Carey St Date signed Jan 27

X

G59493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G59493

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1120 Barclay St
(c) Hospital or institution: 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1120 Barclay St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Tracy

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 219-33-1604

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Teresa C. Tracy
6 (c) If alive, give age → years

7. Birth date of deceased (mo., day, yr.) Dec. 27-1876

8. AGE: Years 71 | Months - | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Tracy
13. Birthplace Boston, Mass

MOTHER
14. Maiden Name Mary Ann Quinn
15. Birthplace Liverpool, England

16 (a) Informant John J. Tracy
(b) Address 1536 N. Milton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof JAN. 28-1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Chas F. Evans & Son
(b) Address 118 W Mt Royal Ave

19 JAN 27 1948 (Date received by Registrar) (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 Jan 1948 at 1 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 23 Jan 1948 to 25 Jan 1948 and that I last saw h[illegible] alive on 25 Jan 1948.

Immediate cause of death: Coronary thrombosis — Duration: 5 days
Due to: arteriosclerosis
Due to: hypertension
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Silverfarb M. D.
Address 714 E. Preston Date signed 27 Jan 48

VS 150

X

C59494 Dr. Stevens

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH (1937)

Registered No. C59494

PRINT OR WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3048 Abell Avenue
(c) Hospital or institution: 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3048 Abell Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WALTER D. RAFFERTY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Bookkeeper
11. Industry or business

FATHER
12. Name John Rafferty
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary Engle
15 Birthplace Penn.

16 (a) Informant Mrs. Mary L. Rafferty
(b) Address 3048 Abell Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location City

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREENMOUNT AVE & 22ND

19 JAN 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/25/48 19 at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1937 to Jan 25 1948 and that I last saw him alive on Jan 25 1948

Immediate cause of death Cerebral Hemorrhage — Duration 18 hrs.
Due to Hypertensive Cardio-Vascular Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. B. Stevens M.D.
Address 3402 Orleans Date signed 1/27/48

VS 150

C59495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C59495

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp. 16-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Callahan

3 (b) If veteran, name war

3 (c) Social Security Account No. 205-12-2158

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Kansas City / Kansas
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name George Callahan
13. Birthplace St. Louis Mo.

MOTHER
14. Maiden Name unknown.
15. Birthplace Mississippi

16 (a) Informant John. Small Wood
(b) Address 1032 - Wilmer Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location West Port Balto. Md.

18 (a) Funeral director Metropolitan Funeral Home Inc.
(b) Address 927. N. Mount St.

19 (Date rec'd by Registrar) JAN 27 1948 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/27 1948, at 10 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic P.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 1/28/48

VS 151

X

G59496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G59496

PRINT WHITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2446 Druid Hill Ave.
(c) Hospital or institution: 13-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2446 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jane Lucas Tilghman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1891

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Fredricksburg, Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15 Birthplace

16 (a) Informant John Tilghman
(b) Address 2446 Druid Hill Ave.

17 (a) Burial (b) Date thereof 1 28 '48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Brooklyn, Md.

18 (a) Funeral director Joseph L. Russ
(b) Address 1200 McCulloh Street

19 (a) [illegible] (b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1948, at 6 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1944 to Jan 24 1948, and that I last saw her alive on Jan 22 1948

Immediate cause of death Cardio Vascular Renal Disease — Duration 4 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William Frey M.D.
Address 1928 Penna Ave Date signed 1/26/48

VS 150

G59497

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G59497

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 406 Fawcett St D.O.A
(c) Hospital or institution: 12-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 406 Fawcett St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Mollie E. Sullivan) Mollie E. Sullivan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) About 1873

8. AGE: Years	Months	Days	If less than one day
75 74 Abt. 74 yrs			hr. min.

9. Birthplace Annapolis, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James Sullivan
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. John M. Dawes
(b) Address Annapolis, Md.

17 (a) Burial (b) Date thereof Jan. 29, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Ann's Cemetery
Location Annapolis, Md.

18 (a) Funeral director Wilkes Lamotte
(b) Address 1003 W. Baltimore St.

19 (a) JAN 27 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/27 1948, at 9:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to last death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Schrinks M.D.
Medical Examiner.
Date signed 1/27/48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

G59498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G59498

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE AND JOHN
(c) Hospital or institution: WOMEN'S HOSPITAL 28-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5505 Wayne Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HELEN M. MACNAB (Helen M. Macnab)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife John Brown Macnab
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) October 14, 1892

8. AGE: Years 55 | Months 3 | Days 12 | If less than one day hr. min.

9. Birthplace Scotland (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business HOME

FATHER
12. Name John MacIntyre
13. Birthplace Scotland

MOTHER
14. Maiden Name Mary MacCalman
15. Birthplace Scotland

16 (a) Informant Mr. John B. Macnab
(b) Address 5505 Wayne Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 28, 1948 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn, Md.

18 (a) Funeral director 4520 Liberty Heights Ave.
(Address)

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 January 1948, at 4.10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947, to 26 January 1948, and that I last saw her alive on 26 January 1948

Immediate cause of death: Hypertensive Cardiovascular disease — Duration 1-2 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A Herbert Jr.

Address 20 E. Preston St. Balt. Date signed 26 Jan '48 M. D.

JAN 27 1948

059499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 147c

Registered No. 059499

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3218 Frederick Ave
(c) Hospital or institution: 20-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3218 Frederick Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Heinreich

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-4052

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Clara L.

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Mar. 4-1872

8. AGE: Years	Months	Days	If less than one day
75	10	20	....hr. ....min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Charles Heinreich
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Clara L. Heinreich
(b) Address 3218 Frederick Ave

17 (a) Burial (b) Date thereof Jan 27/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore City

18 (a) Funeral director C. B. Wippert & Son
(b) Address 1300 Eutaw Place

19 JAN 27 1948 (Date rec'd by registrar) (b) Centerville, Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24 - 1948, at 3:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to Jan 24 1948
and that I last saw h[illegible] alive on Jan 24 1948

Immediate cause of death	Duration
Carcinoma of bowel	3 yrs
Due to	
Due to	
Other Conditions Arteriosclerosis - Cardiac - vascular renal disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. W. Collins M. D.
Address 321 Frederick Ave Date signed 1/26/48

V S 150

X

G59500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G59500 Registered No.

The entries on this certificate should be typewritten, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1910 East 28th Street
(c) Hospital or institution: 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1910 East 28th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Marie Shomber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Clarence F. Shomber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 24, 1895

8. AGE: Years	Months	Days	If less than one day
52	2	3	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Matthew Maczis
13. Birthplace Lithuania

MOTHER
14. Maiden Name Augusta Zidler
15 Birthplace Unknown

16 (a) Informant Clarence Shomber
(b) Address 1910 East 28th Street

17 (a) Burial (b) Date thereof 1/30/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory National
Location Baltimore Md

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 JAN 28 1948 (b) Huntington Williams, M.D.
(Registered by local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27, 1948 at 5 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 47 to 26 Jan 1948, and that I last saw her alive on 26 Jan 1948

Immediate cause of death	Duration
Generalized Carcinomatosis	6 months
Due to Carcinoma of cervix	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lee M. Zimmerman M.D.
Address 2058 Hollins Rd Date signed 28 Jan 48

VS 153

659501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 121a

659501 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3814 Harlem Ave.
(c) Hospital or institution: 16-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3814 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Olga S. Miegel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Theodore H. Miegel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1887

8. AGE: Years	Months	Days	If less than one day
60	10	26	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Heil
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Roeth
15. Birthplace Balto. Md.

16 (a) Informant Albert L. Heil, (brother)
(b) Address 2505 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 28/48. (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave. & Gay St.

18 (a) Funeral director Harry H. Winkler
(b) Address 4101 Edmondson Ave.

19 (a) JAN (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24/48. 19 , at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/11 1947 to 1/24 1948
and that I last saw h[illegible] alive on 1/22 1948

Immediate cause of death Ventricular Fibrillation — Duration 1/24/48

Due to Hypertensive Cardio Vascular Renal Disease — Duration 4+ yrs

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. E. Roach M. D.
Address 3629 Edmondson Date signed 1/26/48

R. E. Roach M.D.

G59502

BC: C 82763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

G59502 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2044 E Fairmont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IRIS LEVIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/4/47

8. AGE: Years | Months: 6 | Days: 23 | If less than one day: hr. min.

9. Birthplace: Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name: Daniel
13. Birthplace: Balto Md

MOTHER 14. Maiden Name: Naomi Friedman
15. Birthplace: Balto Md

16 (a) Informant: Daniel Levin
(b) Address: 2044 E Fairmont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28-48 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Mt Carmel
Location:

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 260 Eutaw Place

JAN 28 1948 (Date rec'd by registrar) Waiting for Williams MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/27 1948, at 7:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/24 1948 to 1/27 1948 and that I last saw her alive on 1/27 1948.

Immediate cause of death: Congestive Heart Failure & Pulmonary edema

Due to: Congenital Heart Disease

Due to:

Other Conditions: Mongolism

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Same

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Susman M. D.
Address Sinai Hospital Date signed 1/27/48

VS 150

X

G59503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G59503 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cordova Apts 2C
(c) Hospital or institution Druid Lake Drive 13-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Cordova Apt 2 C (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jesse Fine

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Carrie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1897

8. AGE: Years 51 | Months | Days | If less than one day hr. min.

9. Birthplace Berkley Va (Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business

FATHER
12. Name Jacob
13. Birthplace Russia

MOTHER
14. Maiden Name Leah
15. Birthplace Russia

16 (a) Informant Carrie Fine
(b) Address Cordova Apt 2 C

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-28-48 (month) (day) (year)
(c) Cemetery or crematory Har Israel
Location Southern Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 216 Eutaw Place

19 (a) 4-28 1948 (Date received by registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-26- 1948, at 8A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1948 to Jan 26 1948, and that I last saw him alive on Jan 26 1948.

Immediate cause of death: Coronary Thrombosis — Duration

Due to: ✓

Due to: ✓

Other Conditions: ✓

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leon M. D.
Address 701 Cathedral St. Date signed 4-28-48

X

659504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 659504

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 915 St Barnabas Court
(c) Hospital or institution: 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 915 St Barnabas Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Benjamin Carpenter

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Annapolis Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Jack Carpenter
13. Birthplace Annapolis Md

MOTHER
14. Maiden Name Rebecca Dyer
15. Birthplace Maryland

16 (a) Informant Edward Carpenter
(b) Address 332½ N Mt Meriem St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Baltimore

18 (a) Funeral director Bolton
(b) Address 1463 N. Carey St

19 JAN 28 1948 (Date rec'd by registrar) (b) Curtis F. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 1948, at 330 P M

21. I certify that death occurred on the date above stated; that I attended deceased (from) Jan 20 1948 to 1/26 1948
and that I last saw h[illegible] alive on Jan 25 1948.

Immediate cause of death
Lacerations Stomach
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 6 hr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. J. Stalcup M. D.
Address 17 S Paca Date signed 1/26/48

VS 150

C59505

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. C59505

131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident 16-V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. ~~1409~~ 1409 Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Calvin Barnes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years	Months	Days	If less than one day
35			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Shipping Clerk

11. Industry or business

FATHER
12. Name
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name
15. Birthplace Baltimore, Md.

16 (a) Informant Estelle Barnes
(b) Address 1409 N. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co., Md.

18 (a) Funeral director Geo. H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) JAN 28 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/24 1948, at 7:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/13 1948 to 1/24 1948, and that I last saw h[illegible] alive on 1/24 1948.

Immediate cause of death	Duration
Uremia	
Due to Hypertensive C-V Renal Disease	11 days (estimated)
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Preston Grant M. D.
Address 1514 Division Date signed 1/26/48

VS 150

X

G59506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59506

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: PROVIDENT HOSPITAL 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1920 Division Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David Norrell

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Johanna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/13/1875

8. AGE: Years	Months	Days	If less than one day
72	10	13	hr. min.

9. Birthplace Richmond, Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Johanna Norrell
(b) Address 1920 Division Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof jan. 30, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) JAN 28 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/26/48 1948 at 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1948 to 1/26 1948
and that I last saw h[illegible] alive on 1/24/48

Immediate cause of death	Duration
Cerebral thrombosis	1/22/48
Due to Pt died Paralysis	
Due to Hypertension	1/10/48
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 113 W. Preston St. Date signed 1/29/48

VS 150

G59507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59507

4 131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2036 McCulloh Street

(c) Hospital or institution: 14.3

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2036 McCulloh Street (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA L. WATERS

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 15, 1873

8. AGE: Years	Months	Days	If less than one day
75 74	-	9	hr. min.

9. Birthplace Kingston, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name George Williams

13. Birthplace Kingston, Md.

MOTHER — 14. Maiden Name Hannah ??????

15. Birthplace Kingston, Md.

16 (a) Informant Mrs. Edna Finney

(b) Address 2036 McCulloh Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 29, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion Cemetery

Location Baltimore, Maryland

18 (a) Funeral director Mrs. George H. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) JAN 28 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24 1948, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1947 to 1-24 1948 and that I last saw her alive on 1-24 1948

Immediate cause of death Hypertensive Cardio-Vascular Renal Disease — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. B. Butler M. D.

Address 2033 Eutaw Pl. Date signed 1/28/48

VS 150

G59508

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G59508 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1908 Madison Ave.
(c) Hospital or institution: 14.3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME IRADELL BOND WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Dr. Nelson M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1901

8. AGE: Years	Months	Days	If less than one day
46	7	25	hr. min.

9. Birthplace Baltimore, Maryland. (Town, county, and state)
10. Usual Occupation Vice principal
11. Industry or business Public School

FATHER
12. Name Charles H. Bond
13. Birthplace Baltimore, Maryland.

MOTHER
14. Maiden Name Anna Matthews
15. Birthplace Baltimore, Maryland.

16 (a) Informant Dr. Nelson M. Williams
(b) Address 1908 Madison Ave,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 28, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) JAN 28 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23, 1948, at 3:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 5, 1947 to Jan. 23, 1948, and that I last saw her alive on Jan. 23, 1948.

Immediate cause of death: Bronchogenic carcinoma with primary focus in breast — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation May 1, 1946

Major findings of operation: Carcinoma of right breast

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature O.R. Campbell M. D.
Address 718 Dolphin St. Date signed 1-26-48

VS 150

G59509 AB-116746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G59509 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14.3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5days
(e) Length of stay in Baltimore (yrs., mos., or days) 65yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 McCulloh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eleanor Stegall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12-1879

8. AGE: Years	Months	Days	If less than one day
68	7	13	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name George Lambden-or-Lambdon ?
13. Birthplace

MOTHER
14. Maiden Name Milcah Shreves
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 28, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave

19 JAN 28 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25- 1948, at 6P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-20- 1948; to 1-25- 1948, and that I last saw her alive on 1-25- 1948.

Immediate cause of death	Duration
? Multiple small Cerebral thrombosis	
Cardiac failure	
Due to Hypertensive Arteriosclerotic	
Cardiovascular Disease.	
Due to 0	
Other Conditions Arteriolarnephro-	
sclerosis.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy Renal Congestion.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. T. Bamford M. D.
Address Balt. City Hosp. Date signed 1-26-48

VS 150

937

G59510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59510

1937 Dr. Campbell

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1716 N. Mount Street

(c) Hospital or institution: 15.2

(d) Length of stay in hospital or inst. (yrs., mos., or days):

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1716 N. Mount Street (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES WALTER WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-2885

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Hattie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 3, 1889

8. AGE: Years	Months	Days	If less than one day
60	4	23	hr. min.

9. Birthplace Fernandia, Florida (Town, county, and state)

10. Usual Occupation Night watchman

11. Industry or business

FATHER

12. Name UNKNOWN

13. Birthplace

MOTHER

14. Maiden Name UNKNOWN

15. Birthplace

16 (a) Informant Mrs. Hattie Williams

(b) Address 1716 N. Mount Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 28, 1948 (month) (day) (year)

(c) Cemetery or crematory Family lot

Location Boydton, Va.

18 (a) Funeral director Mrs. George H. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) JAN 28 1948 (Date rec'd by Registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26, 1948, at 6:48 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 23, 1948, to Jan. 26, 1948, and that I last saw him alive on Jan. 26, 1948.

Immediate cause of death Cerebral accident — Duration

Due to hypertensive cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C.R. Campbell M. D.

Address 718 Dolphin St. Date signed 1-26-48

VS 150

X

G59511

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G59511
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1108 Argyle Avenue
(c) Hospital or institution: 17-V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 Argyle Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HOWARD JONES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	married

6 (b) Name of husband or wife Ellen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-11-1893

8. AGE: Years	Months	Days	If less than one day
54 55	10	15	hr. min.

9. Birthplace Isle of Wight Co. Va (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Phillip Jones
13. Birthplace Va

MOTHER
14. Maiden Name Amanda Patterson
15. Birthplace Middlesex Co. Va

16 (a) Informant Mrs. Ella Jones
(b) Address 1108 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-30-48 (month) (day) (year)
(c) Cemetery or crematory Columbus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Lee A. Mulligan
(b) Address 1631 Druid Hill Ave.

19 JAN 28 1948 (Date rec'd by registrar) Hunter for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26, 1948 at 10.05 P.M.

21. I certify that I took charge of the remains described above, held an insp & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary artery disease.
Myocardial degeneration.

Due to

Other Conditions Bronchial asthma.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Mavill M.D. Medical Examiner.
Date signed 1-27 48

VS 151

X

C59512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C59512

GM. 115503 186a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 21-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 736 MCHenry ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louise Emerick (Louisa Emrick)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Henry Emerick (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10-1867

8. AGE: Years	Months	Days	If less than one day
80	5	16	hr. min.

9. Birthplace MD. Baltimore (Town, county, and state)
10. Usual Occupation House Work
11. Industry or business at home

FATHER
12. Name Henry Emerick ? (D)
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa Emerick (D)
15. Birthplace Germany

16 (a) Informant records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/48 (month) (day) (year)
(c) Cemetery or crematory London Park Cem.
Location 3801 Frederick Ave

18 (a) Funeral director John J. Govan & Son Stopped Drug & fell to floor
(b) Address 901-03 Hollins St

19 (a) JAN 28 1948 (Date rec'd by registrar) Lucius Williams, M.D. Registrar

To be approved by Medical Examiner

VS 150 WILLIAM G. HELFRICH, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-26-48 1948 at 1.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27-1948 to 1-26-1948 and that I last saw her alive on 1-26-1948.

	Duration
Immediate cause of death Cardiac failure	min
Due to ASCVD	yrs
Due to	
Other Conditions enter-trochanteric fract. of femur, left; decubitus ulcer (Include pregnancy within 3 months of death)	2 mos

Date of operation no
Major findings of operation: —
of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 21/1
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 11/27/47 at 11 A M
(c) Where did injury occur? Balt (City or town) Balt (County) md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury

23. Signature Gordon Craft
Address Balt. City Hosp. Date signed 1/29/48 M. D.

G59513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 131a

G59513
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette and Calhoun Sts
(c) Hospital or institution:
Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15da
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3643 Coolidge Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes R. Goshell

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
F	W	

6 (b) Name of husband or wife William B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 14, 1880

8. AGE: Years	Months	Days	If less than one day
67	4	13	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation House Work
11. Industry or business at home

FATHER
12. Name David Bury
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Margaret Kemp
15. Birthplace Baltimore Md

16 (a) Informant Mr Irving E. Goshell
(b) Address 3643 Coolidge Ave

17 (a) Burial (b) Date thereof 1/30/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Cannon Inc
(b) Address 904-03 Rutland St

19 (a) JAN 28 1948 (b) Hunting for Williams M.F.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1948, at 6:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1948, to Jan 27 1948, and that I last saw her alive on Jan 27 1948.

Immediate cause of death	Duration
(a) Bronchopneumonia	
Due to	
Due to	
Other Conditions Arteriosclerotic C.V. disease Chronic syphilis & anemia (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. Bailey L. Jones M. D.
Address Franklin Square Hosp. Date signed 1/27/48

VS 150

107

G59514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G59514
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4211 Pennhurst Ave
(c) Hospital or institution: — 28-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4211 Pennhurst Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Addie N. Barrick

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W. | 6 (a) ~~Single, married~~, widowed, or divorced Widow

6 (b) Name of husband or wife Albert M. Barrick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 8 1874

8. AGE: Years 74 | Months 0 | Days 18 | If less than one day hr. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Benjamin Leach
13. Birthplace Washington D.C.

MOTHER 14. Maiden Name Martha A. Bates
15. Birthplace Washington D.C.

16 (a) Informant Mrs. Wm. H. Waesche
(b) Address 4211 Pennhurst Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29 1937 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Edward F. Foley
(b) Address 2324 N. Charles St.

JAN 28 1937 (Date rec'd by Registrar) (Signature of Registrar) Huntington Williams Mgr.

MEDICAL CERTIFICATION

20. **DATE OF DEATH** Jan 26th 1937, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan - 21 1937, to Jan - 26 1937, and that I last saw her alive on Jan. 26 1937.

Immediate cause of death

(1) - Coronary Thrombosis. — Duration 6 hours.

Due to —

Due to - Arteriosclerosis — 5 yrs. ?
Heart Disease

Other Conditions - Chronic — 5 yrs.
Infected Gall Bladder
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Earl L. Chambers M. D.
Address 4108 Liberty Hts Date signed 1/28/37

VS 150

X

G59515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G59515

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eutaw Place & Wilson St. Marlborough Apts.
(c) Hospital or institution: 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Marlborough Apts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MYRA R. HUTZLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Isaac Hutzler.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 8, 1868.

8. AGE: Years	Months	Days	If less than one day
79	10	19	hr. min.

9. Birthplace Richmond, Va. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Leopold Rose,
13. Birthplace Unknown.

MOTHER
14. Maiden Name Hannah ?
15. Birthplace Unknown.

16 (a) Informant Mr. Harry Myers,
(b) Address 2015 Greenbury Road.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 1.28.48. (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto. Md.

18 (a) Funeral director Harris Levin Colston & Sons
(b) Address 1902 Eutaw Place.

19 (a) JAN 28 1948 (Filed record by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27th. 1948 at 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1. 1938 to Jan 27 1948. and that I last saw h[illegible] alive on Jan 27 1948.

Immediate cause of death — Duration
Acute Coronary Thrombosis — 2 hrs.
Due to arteriosclerosis
Cardiac Insuff — years.
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature Bernard J. Cohen M. D.
Address Marlborough Apts. Date signed

VS 150

G59516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC-G95025 107

Registered No. G59516

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1605 Penna ave
(c) Hospital or institution: 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Penna ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Leroy P. Jones

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/20/47

8. AGE: Years	Months	Days	If less than one day
	2	7	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Albert Jarrett

13. Birthplace Md

MOTHER 14. Maiden Name Dorothy Jones

15. Birthplace Md

16 (a) Informant Dorothy Jones

(b) Address 1605 Penna Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/30/48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director Geo. H. Nelson

(b) Address 1303 Pennsylvania Ave

19 JAN 28 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27 1948, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-24 1948 to 1-27 1948 and that I last saw h/m alive on 1-27 1948

Immediate cause of death Bronchopneumonia — Duration 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.

Address 1543 Penna Ave Date signed 1/28/48

V S 150

X

G59517

AB-116803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G59517 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 14-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4days

(e) Length of stay in Baltimore (yrs., mos., or days) 26yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1417 Pennsylvania Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Emma Ball Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1-1913

8. AGE: Years	Months	Days	If less than one day
34	6	25	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Warren Ball

13. Birthplace Va.

MOTHER

14. Maiden Name Cora Tolyer

15. Birthplace Va.

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director Wes. H. Nelson

(b) Address 6306 Frankford Ave

19 JAN 28 1948 (Date rec'd by registrar) Hattie Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26 1948, at 5.10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-22 1948 to 1-26 1948, and that I last saw her alive on 1-26 1948.

	Duration
Immediate cause of death Massive pulmonary hemorrhage	
Due to Bilateral pulmonary tuberculosis	
Due to	
Other Conditions Secondary Syphilis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

Signature Palmer H. Miller M. D.

Address Balto City No 3/0 Date signed 1/27/48

VS 150

X

G59518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59518 ✓ 122a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Room + Hallway

(c) Hospital or institution W. Balto. Gen. Hosp. 19-1

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 535 N. Fulton Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** John Townshend

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Clara May

6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) Oct. 11-1870

8. AGE: Years	Months	Days	If less than one day
77	3.	14	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name C. Townshend

13. Birthplace Maryland

MOTHER 14. Maiden Name Elizabeth Thomas

15. Birthplace Maryland

16 (a) Informant J. Oscar Townshend

(b) Address Westwood - Md. - Brandywine

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 28/48 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location A.A.C. Md.

18 (a) Funeral director F.B. Wippert + Son

(b) Address 1300 Eutaw Place 17

JAN 28 1948 (a) date rec'd by registrar (b) Registrar acting for Williams M.D. registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-25- 1948, at 2:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-23- 1948 to 1-25 1948, and that I last saw him alive on 1-25 - 1948.

Immediate cause of death	Duration
Cerebral Vascular accident	
Due to Hypertension	
Due to Arteriosclerosis	
Other Conditions Bilateral inguinal hernia	

(Include pregnancy within 3 months of death)

Date of operation 1-23-48

Major findings of operation: Strangulated inguinal hernia - right

of autopsy: Cerebral hemorrhage - right

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W.W. Baldwin M.D. M.D.

Address W. Balto Gen. Hosp. Date signed 1-26-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. G59519

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2710 Wilkens Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2710 Wilkens Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Bozel Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-05-6025

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Sarah C.

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) July-15-1892

8. AGE: Years	Months	Days	If less than one day
55	6	11	____ hr. ____ min.

9. Birthplace Baltimore - Md. (Town, county, and state)

10. Usual Occupation Yard foreman

11. Industry or business B & O. R.R.

FATHER
12. Name Forrest P. Bozel
13. Birthplace Virginia.

MOTHER
14. Maiden Name Anna E. Sakumcut
15. Birthplace New York.

16 (a) Informant Mrs. Cassie T. Mooney
(b) Address 2710 Wilkens Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 29-Jan.-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore - Md.

18 (a) Funeral director E. R. Wippert & Son
(b) Address 1300 Eutaw Pl. 17

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

JAN 28 1948

Phoning for William

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26. 1948, at 7:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1948 to Jan 26 1948, and that I last saw deceased alive on Jan 26 1948.

Duration

Immediate cause of death Pulmonary Oedema

Due to Bronchopneumonia Coronary Thrombosis

Due to

Other Conditions Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert W. Mitchell M.D.
Address 251-W Wilkens Ave Date signed 1/27/48

X

G59520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G59520 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1731 Ellsworth St.
(c) Hospital or institution: 8.7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1731 Ellsworth St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Myers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W C	Widower

6 (b) Name of husband or wife Nannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1881

8. AGE: Years	Months	Days	If less than one day
66	11	13	hr. min.

9. Birthplace Cockeysville Md.
(Town, county, and state)

10. Usual Occupation Unemployed Laborer

11. Industry or business

FATHER
12. Name Abraham Myers
13. Birthplace Md.

MOTHER
14. Maiden Name Mary ?
15. Birthplace Md.

16 (a) Informant Ada Myers
(b) Address 1731 Ellsworth St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location A.A. County Md.

18 (a) Funeral director Mrs. Robt A. Elliott & Daughter
(b) Address 1129 N. Carolina St.

JAN 28 1948 (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-25 1948, at 8 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14 1947, to 1-25 1948 and that I last saw him alive on 1-16 1948.

Immediate cause of death Cerebral hemorrhage — Duration seven hrs

Due to hypertensive cardiovascular disease

Due to

Other Conditions paralysis agitans

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rayner Brown M. D.

Address 1500 E. Madison St. Date signed 1-27

Rayner Brown x

C59521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

C59521 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3407 Walbrook Ave.
(c) Hospital or institution: 15.6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3407 Walbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Burns Hargett Waters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Ruth Williamson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1893.

8. AGE: Years	Months	Days	If less than one day
54	3	25	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Waters Rubber Co.
11. Industry or business Own business

FATHER
12. Name Late Dr. R. Frank Waters
13. Birthplace Md.

MOTHER
14. Maiden Name Ida Tracey
15. Birthplace Md.

16 (a) Informant Mrs. Ida Waters, (Mother)
(b) Address 3407 Walbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 29/48. (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Harry A. Tuttle.
(b) Address 4101 Edmondson Ave.

19 (a) 1948 (b) Date rec'd by reg. Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29/48 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1948 to Jan. 26 1948, and that I last saw him alive on Jan. 25 19 48.

Immediate cause of death	Duration
Coronary Thrombosis	10 Years
Due to arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gilbreth Mortimer Jr. M.D.
Address 2706 St Paul St Date signed 1/28/48

VS 150

G59522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G59522 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4211 White Ave.,
(c) Hospital or institution: 26-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4211 White Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROLAND W. CARTER

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-0989

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7th, 1905

8. AGE: Years	Months	Days	If less than one day
43		20	hr. min.

9. Birthplace Baltimore County, Md.,
(Town, county, and state)

10. Usual Occupation Textile Salesman

11. Industry or business

FATHER
12. Name Wm. H. Carter
13. Birthplace Baltimore County, Md.,

MOTHER
14. Maiden Name Emma M. Evans
15. Birthplace Baltimore County, Md.,

16 (a) Informant Mrs. Mabel C. McLeod
(b) Address 4211 White Ave.,

17 (a) burial (b) Date thereof 1/30/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson, Md.

18 (a) Funeral director Lazenby Funeral Home
(b) Address 7401 Belair Road

19 (a) (Date Received by Registrar) (b) Registrar

JAN 28 1948

Form 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Jan. 27th, 1948, at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from February 1920, to Jan. 27, 1948 and that I last saw him alive on Jan. 27, 1948.

Immediate cause of death	Duration
Cardio-renal Disease	28 yrs.
Due to Rheumatic Endocarditis	28 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Wilkinson.
A. L. Wilkinson M. D.

Address 5713 Belair Rd. Date signed 1-28-48

G59523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

446

G59523 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1815 E. 33RD STREET
(c) Hospital or institution: 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 1/2 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 E. 33RD. ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BENJAMIN OWEN ALMONEY

3 (b) If veteran, name war: NONE.

3 (c) Social Security Account No. 346-09-7373

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of ~~husband~~ or wife GRACE FORRA ALMONEY

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) JUNE 8, 1900

8. AGE: Years 47 | Months 7 | Days 21 20 | If less than one day: hr. min.

9. Birthplace NORRISVILLE HARFORD Co., MD.
(Town, county, and state)

10. Usual Occupation SALESMAN

11. Industry or business TOLEDO SCALE Co.

FATHER
12. Name J. OWEN ALMONEY
13. Birthplace NORRISVILLE, MD.

MOTHER
14. Maiden Name SALLY HUGHES
15. Birthplace NORRISVILLE MD.

16 (a) Informant MRS. GRACE ALMONEY
(b) Address 1815 E. 33RD ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-30-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Keck
(b) Address 5305 Harford Road

19 (a) 1948 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 28 1948 at 3:15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from OCT. 10 1947 to JAN. 28 1948, and that I last saw him alive on JAN. 27 1948.

Immediate cause of death: HODGKINS DISEASE — Duration: 4 1/2 Mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation BIOPSY - 12/18/47

Major findings of operation: BIOPSY OF GLAND

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur Karfgin M. D.
Address 4230 HOCH RAVEN BLVD. Date signed 1-28-48

VS 150

X

G59524 ✓ × G59524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene St.
(c) Hospital or institution: University Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2823 Druyf Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Bowker, Mary V. Hoffman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Widowed

6 (b) Name of husband or wife Charles P.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 23-1886

8. AGE: Years	Months	Days	If less than one day
61	10	5	hr. min.

9. Birthplace Balto, Md.
(Town, county and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ✓
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Mrs. Clarence Sunderland
(b) Address 1719 Jackson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-31-48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Balto.

18 (a) Funeral director Lemuel J Luck
(b) Address 5305 Harford Rd.

19 (a) (Entered later by the registrar) (b) Clayton Will Registrar M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 1948, at 3 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 27 1948 to Jan 28 1948, and that I last saw her alive on Jan 28 1948.

Immediate cause of death Cerebral hemorrhage

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lee Young Jr M.D.
Address Univ. Hosp. Date signed 1/29/48

150

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G59525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12 1a

G59525 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Monkford ave
(c) Hospital or institution: 8-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4e

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 N Monkford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Viva M. STOOS

3 (b) If veteran, name war No | 3 (c) Social Security Account No. No

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Lew Stoos
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) October 1 - 1880

8. AGE: Years 67 | Months 3 | Days 25 | If less than one day 24 hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Frederick G. Trautman
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Farrow
15. Birthplace Md

16 (a) Informant Lew Stoos (Husband)
(b) Address 1400 N. Monkford Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29 48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North ewg

18 (a) Funeral director Leo J. Cook
(b) Address 1701-3 Patterson Pk Ave

19 (a) (b) Date rec'd by registrar 1-28-1948 Clayton Williams, Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 1948, at 7 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28 1948 to Jan 25 1948, and that I last saw h[illegible] alive on Jan 25 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	3 hr.
Bronchial Pneumonia	10
Due to Arterio Sclerosis	2 wks
Hypertension	2 wks
Due to Chr. Interstitial Nephritis	2 wks
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. F. A. Stoos M. D.
Address 2876 Harford Rd Date signed 1-28-48

G59526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G59526
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2113 Barclay St
(c) Hospital or institution: 12-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2113 Barclay St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John S. Fackler
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, ~~married~~, widowed, or ~~divorced~~.
Male	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 9th 1864

8. AGE: Years	Months	Days	If less than one day
83	5	18	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER | FATHER
12. Name John Fackler
13. Birthplace Va.
14. Maiden Name Mary E. Emerson
15. Birthplace Va.

16 (a) Informant Mrs. Lena Partlow
(b) Address 2113 Barclay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location

18 (a) Funeral director Leo B. Leach
(b) Address 1701-03 N. Patterson Park ave

(a) JAN 28 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27th 1948; at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1946, to Jan 27 1948 and that I last saw h[illegible] alive on Jan 15 1948.

Immediate cause of death	Duration
Coronary disease	
Due to	
Due to Arteriosclerosis Cardiovascular disease	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack J. Singer M.D.
Address 506 E. North Ave Date signed 1-28-48 M.D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G59527
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2105 Pressbury St
(c) Hospital or institution: 153
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2105 Pressbury St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Selbert

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Lillian
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Max
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Lillian Selbert
(b) Address 2105 Pressbury St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd + Hamilton Ave

18 (a) Funeral director Jack Levow, Inc
(b) Address 2100 Eastern Place

19 (a) JAN 28 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-28-1948, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1947, to Jan. 28 1948, and that I last saw him alive on 1/28/48

Immediate cause of death	Duration
Coronary Occlusion	20 minutes
Due to Chr. Myocarditis	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Saruben
Address 2128 W North Ave Date signed 1/28/48

Saruben X

VS 150

G59528

BALTIMORE CITY HEALTH DEPARTMENT ✓ G59528

Registered No.

CERTIFICATE OF DEATH 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 27-B
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt city
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 Gladstone
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Howard P. Russell HOWARD D RUSSELL

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: ?

4. Sex: M

5. Color or race: W

6 (a) Single, (married) widowed, or divorced.

6 (b) Name of ~~husband~~ wife: Bessie Marks Russell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 16, 1886

8. AGE: Years 63 | Months 0 | Days 11 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Shipping Clerk

11. Industry or business

FATHER
12. Name Charles Russell
13. Birthplace Scotland

MOTHER
14. Maiden Name Mary Catherine Mills
15. Birthplace England

16 (a) Informant Mrs. Bessie Marks Russell
(b) Address 700 Gladstone Ave.

17 (a) Burial (b) Date thereof 1/30/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Pk Cem.
Location Balto Md.

18 (a) Funeral director Wm. J. Tickner & Sons Inc
(b) Address North & Pa. Aves Balto 17, Md.

19 (a) Date received by registrar JAN 28 1948 (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27, 1948, at 1:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 1-27- 19 48.

Immediate cause of death Acute pulmonary edema — Duration

Due to Acute left ventricular failure

Due to Acute anterior coronary occlusion

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ~~1-27-48~~ at ~~1:25~~ P.M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Barnett Gold M. D.
Address University Hosp. Date signed 1-27-48

X

G59529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G59529 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The coroner's office is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 241 S. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William T. Wilson (or) Theodore W. Wilson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Frances
6 (c) If alive, give age 57 years
7. Birth date of deceased (mo., day, yr.) Aug 9 1894
8. AGE: Years 53 Months 5 Days 15 If less than one day hr. min.
9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation
11. Industry or business Labor.

FATHER
12. Name Luther J. Wilson
13. Birthplace Balto.

MOTHER
14. Maiden Name
15. Birthplace Balto.

16 (a) Informant Frances Wilson
(b) Address 729 S. Luzerne Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 29 48 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location O'Donnell St

18 (a) Funeral director The Dippel Bros.
(b) Address 1600 E Lombard St

19 (a) Date rec'd by registrar JAN 28 1948 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27, 1948 at 5 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Myocardial hypertrophy and dilatation
Pulmonary edema.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 1/28/48

BC-C 91162
G59530

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

G59530
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 30E 11-4
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. 302 W. Hoffman (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country No

3 (a) FULL NAME Michael Washington

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race B | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 11, 1947.

8. AGE: Years | Months 3 | Days 16 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name James
13. Birthplace Md.

MOTHER
14. Maiden Name Eva
15. Birthplace N.C.

16 (a) Informant Eva Washington
(b) Address 302 W. Hoffman

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 29, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. K. R. Williams
(b) Address 322 N. Schroeder St.

19 (a) JAN 28 1948 (Date rec'd by registrar) (Funeral director) Williamsville, Md.

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27 1948, at 4:04 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 1948 to Jan. 27 1948, and that I last saw him alive on Jan. 27 1948.

Immediate cause of death Respiratory Failure;
Due to obstruction of bronchi - bronchial type
Due to aspiration of vomitus
Other Conditions Bronchiolitis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. C. Hunter, M.D.
Address Univ. Hosp. Date signed Jan 27 1948

114E

659531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54B

659531 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18-1
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 864 W. Fayette St (If rural give location)
(e) Citizen of foreign country? / (Yes or No)
If yes, name country

3 (a) FULL NAME Adrian Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-13-45

8. AGE: Years 2 | Months 6 | Days 14 | If less than one day hr. min.

9. Birthplace Florida (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Bell
13. Birthplace Virginia

MOTHER 14. Maiden Name Irene Lowier
15. Birthplace Georgia

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 31, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. K. R. Williams
(b) Address 322 N. Schroeder St.

19 (a) 1948 (b) [illegible] for Williams, undertaker

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27 1948, at 9 40A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 11 1947, to Jan. 27 1948, and that I last saw h[illegible] alive on Jan. 26 1948

Immediate cause of death: Respiratory Cessation — Duration: 3 mo

Due to: Cerebellar Tumor — Duration:

Due to: Malignant - Type Not Specified — Duration:

Other Conditions — Duration:

(Include pregnancy within 3 months of death)

Date of operation 11-22-47

Major findings of operation: Cerebellar Tumor -

of autopsy: Negative

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip Pfeiffer M. D.

Address Johns Hopkins Hosp Date signed 1-27-48

VS 150

G59532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G59532 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 509 Claggett Alley
(c) Hospital or institution: 17-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 509 Claggett Alley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN W. H. CONNOR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife Clara Connor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 22, 1870

8. AGE: Years	Months	Days	If less than one day
77	3	5	hr. min.

9. Birthplace Smithfield, Virginia.
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Stephen Connor
13. Birthplace South Mills, N.C.

MOTHER
14. Maiden Name Christanna, N.C.
15. Birthplace City Point, Virginia

16 (a) Informant Susie Cash
(b) Address 744 Pierce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 30 1948 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St,

19 (a) JAN 28 1948 (Date rec'd by registrar) (b) Katie R. Williams Registrar

VS 191

MEDICAL CERTIFICATION

P

20. DATE OF DEATH January 27 1948, at 12:10 M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl H. Reyer M.D.
Medical Examiner.
Date signed 1-28-48

X

G59533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G59533 Registered No.

8 3a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 721 W. Cross St.
(c) Hospital or institution: 21-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 721 W. Cross St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Kershner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Widow

6 (b) Name of husband or wife Late Louis Kershner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1862

8. AGE: Years	Months	Days	If less than one day
85	2	9	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER | FATHER

12. Name George Hoehn

13. Birthplace Germany

14. Maiden Name Rose Schmidt

15. Birthplace Germany

16 (a) Informant Miss Bertha Kershner

(b) Address 721 W. Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 29/48 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location North Ave. & Gay St.

18 (a) Funeral director Harry H. Mutzfeldt

(b) Address 4101 Edmondson Ave.

JAN 28 1948 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/25/1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24th 1948 to Jan 25th 1948, and that I last saw her alive on Jan 25th 1948.

	Duration
Immediate cause of death: Cerebral Hemorrhage	4 days
Due to: Hypertension —	7 years
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Hoehn, M. D.

Address 517 Acorn St. Date signed 1/27/48

VS 150

G59534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G59534 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

27-8

(a) Baltimore City, Maryland

(b) Street address Wyman Park Drive & 31st S t.

(c) Hospital or institution: U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hour

(e) Length of stay in Baltimore (yrs., mos., or days) 60 yr.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5841 York Rd. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Kerr, William Lyle

3 (b) If veteran, name war ~~WWII~~

3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	w	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 20, 1878

8. AGE: Years	Months	Days	If less than one day
69	9	6	hr. min.

9. Birthplace Chicago, Ill. (Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business Seafarer

FATHER

12. Name Robert Kerr

13. Birthplace Balto, Md

MOTHER

14. Maiden Name Barbara Reid

15 Birthplace England

16 (a) Informant Records.

(b) Address U S Marine Hospital, Balto, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jany 29/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell Sons

(b) Address 1900 Eutaw Place

19 (a) 1-28-1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26, 1948, at 8 55PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 26, 1948 to Jan. 26, 1948, and that I last saw him alive on Jan. 26, 1948.

	Duration
Immediate cause of death Cerebral hemorrhage due apparently to hypertensive cardiovascular disease	unknown
2 Multiple contusions, cause unknown	unknown
3 Bilateral enlargements in adrenal glands	unknown
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John L. Wilson, Sr. Surgeon M. D.

Address U. S. Marine Hospital Date signed 1-27-48

Baltimore 11, Md.

VS 150

For a W.H. Cummings, Jr., by Heirs of Mercer, Inc

G59535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

G59535 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 33rd & Calvert 13
(b) Street address 600 W University Parkway
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 600 W Univ Parkway. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Willard Wilson Trowell.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	md.

6 (b) Name of husband or wife Daisy Wood Trowell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 22, 1893

8. AGE: Years	Months	Days	If less than one day
54 (55)	10	205	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation engineer
11. Industry or business

FATHER
12. Name Frederick Trowell
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Hopkins
15. Birthplace Md.

16 (a) Informant wife
(b) Address above

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jany. 29/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Ave

18 (a) Funeral director John D. Mitchell Sons
(b) Address 1960 Eutaw Place

19 (a) (State fact given by registrar) (b) Attending from Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-27-48 19 , at 3.05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 1948 to Jan 27 1948, and that I last saw h. alive on Jan 26 1948.

Immediate cause of death	Duration
Uraemia	
Due to acute hemorrhage nephritis	
Due to gen. arteriosclerosis.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: hemorrhagic nephritis, pericarditis, adhesive
of autopsy: gen. arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. C. Clemens M.D.
Address Union Mem Hosp Date signed 1-27-48.

VS 150

G59536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157F

Registered No. G59536

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1809 Hennenman Ave.

(c) Hospital or institution: 8-7

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 1809 Hennenman Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clifford E. Rule

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dorothy Rule

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2 - 1927

8. AGE: Years: 20 | Months: 8 | Days: 24 | If less than one day: hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business

FATHER

12. Name George E. Rule

13. Birthplace Pa.

MOTHER

14. Maiden Name Ethel M. Rhoades

15. Birthplace Pa.

16 (a) Informant George E. Rule

(b) Address 1809 Hennenman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 29-48 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Ritchie Highway

18 (a) Funeral director John G. Miller

(b) Address 2334 Jefferson St.

19 (c) (Date received by registrar) JAN 28 1948 (b) Huntington Woods, Md. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26th 1948, at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 1948 to Jan 26th 1948, and that I last saw h alive on Jan 24th 1948.

Immediate cause of death	Duration
Pneumonia acute	one day
Due to Congenital Coarctation of the aorta	2
Due to Coronary Hypertension	2
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. J. Sanker M. D.

Address 1006 Mulberry Date signed 1/27/48

G59537

449 447.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G59537

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 E. 32nd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Virginia Klaemer

3 (b) If veteran, name war: N

3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife: William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-31-04

8. AGE: Years	Months	Days	If less than one day
43	2	26	hr. min.

9. Birthplace: md. (Town, county, and state)

10. Usual Occupation: House-wife

11. Industry or business

FATHER — 12. Name: William J. Goldsborough

13. Birthplace: Leonardstown, Md.

MOTHER — 14. Maiden Name: Anna Ainsworth

15. Birthplace: Leonardstown, Md

16 (a) Informant: Records

(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/48 (month) (day) (year)

(c) Cemetery or crematory: New Cathedral

Location: Baltimore

18 (a) Funeral director: Wm. Cook, Inc.

(b) Address: 1217 St. Paul Street

19 (a) JAN 28 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27. 1948, at 1.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 24 1948 to Jan. 27 1948, and that I last saw her alive on Jan. 27 1948.

	Duration
Immediate cause of death: Ventricular fibrillation	Seconds
Due to: Coronary occlusion	2 days
Due to: Hypertension, arteriosclerosis, chronic heart disease	4 years
Other Conditions: Mesonephroma	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: —

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: H. H. Gibson M. D.

Address: Johns Hopkins Hosp. Date signed: 27 Jan 48

X

G59538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G59538

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St 10
(c) Hospital or institution: Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Holmes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Philip Holmes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882 1866

8. AGE: Years 82 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Martin —
13. Birthplace

MOTHER 14. Maiden Name Celine —
15. Birthplace

16 (a) Informant Mrs. Lina Jones Powell
(b) Address 1201 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 29, 1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wuchfeld
(b) Address 900 E. Biddle St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION attd

20. DATE OF DEATH Jan. 27 1948, at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1948, to Jan. 27 - 1948, and that I last saw h. alive on Jan 26 1948.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic Myocarditis	6 yrs
Due to	
Other Conditions Arterio Sclerosis	10 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E. North Av Date signed 1/28/48

JAN 28 1948

JAN 28 1948

DR. P. ARTICIANI
2942 E. FAYETTE.

G59539

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G59539
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 440 E 22nd St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 440 E 22nd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAUD M. EGAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) 1873

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Balto.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Michael Egan
13. Birthplace Ireland

MOTHER
14. Maiden Name Rose McCormack
15 Birthplace Ireland

16 (a) Informant Miss Julia Egan
(b) Address 440 E 22nd St

17 (a) Burial (b) Date thereof 1-29-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Wiedefeld & Son
(b) Address Green Mount Ave & 22nd

19 (a) 1-28-1948 (Signature of Registrar) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-25-48 19 , at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 20, 19 47 to Jan. 25, 19 48 and that I last saw her alive on Jan. 25, 19 48.

Immediate cause of death	Duration
Congestive Heart Failure	1 day
Due to Myocardial Damage	Unknown
Due to Arteriosclerosis	Unknown
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Philibert Articiani M. D.
Address 2942 E. Fayette St. Date signed 1/28/48

VS 150

G59540

JL 116911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 13 B

G59540 ✓ Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 8
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2452 Greenmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Wilson Goodling

3 (b) If veteran, name war: World War # 1
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1893

8. AGE: Years	Months	Days	If less than one day
55	6	23	hr. min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation Paper Mill Worker
11. Industry or business

FATHER
12. Name Paul P Goodling
13. Birthplace ? Penna.

MOTHER
14. Maiden Name Idaline Huppman
15. Birthplace ? Penna.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 31, 1948 (month) (day) (year)
(c) Cemetery or crematory Mount Carmel Cem.
Location York County Penna.

18 (a) Funeral director H. Sander & Sons.
(b) Address 1649 E. North Ave.

19 (a) Date received by registrar JAN 28 1948 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26 1948 at 3.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 26 1948 to Jan. 26 1948, and that I last saw him alive on Jan. 26 1948.

Immediate cause of death	Duration
Pulmonary Tuberculosis	7
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. C. Rahenmaier
Address Balt. City Hosp. Date signed 1/31/48 M.D.

G59541
449532

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

55E

Registered G59531

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County
(c) City or town Miami
(If outside city or town limits, write RURAL and give town)
(d) Street No. Pittsburgh Hotel (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry K Hungary

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male.	White	married

6 (b) Name of husband or wife: Hazel Virgus
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 8-20-1885

8. AGE: Years	Months	Days	If less than one day
62	5	1	hr. min.

9. Birthplace: Ohio. (Town, county, and state)
10. Usual Occupation: Mechanical Dept
11. Industry or business: White Co, Ny.

FATHER
12. Name: Lawrence Hungary
13. Birthplace: Ohio

MOTHER
14. Maiden Name: Della Wade.
15. Birthplace: Ohio

16 (a) Informant: Rhonda.
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/29/48 (month) (day) (yr)
(c) Cemetery or crematory: Odd Fellows
Location: New Haven Indiana

18 (a) Funeral director: Wm. J. Tickner & Sons
(b) Address: North & Pa. Aves.

19 (a) Filed JAN 29 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27 1948 at 11.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 27 1948, to Jan. 27 1948, and that I last saw h[illegible] alive on Jan 27 - 1948.

Immediate cause of death: Carcinoma Testis generalized — Duration: ?
Due to:
Due to:
Other Conditions: Uremia — Duration: 4 days
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: Jan 28, 1948

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: I Marion 1st Day M.D.
Address: Johns Hopkins Hosp. Date signed 1-28-48

G59542 BC - 48-01750

AB-116661

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 159

G59542 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1hr-21min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 27 N. Curley Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16-1948

8. AGE: Years	Months	Days	If less than one day
			1 hr. 21 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Donald Williams
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Swanson
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) cremated (Burial, cremation, or removal) (b) Date thereof 1-19-48 (month) (day) (year)
(c) ~~Cemetery~~ or crematory Balto City Hosp
Location 4940 Eastern Ave

18 (a) Funeral director Balto City Hosp
(b) Address

19 (a) JAN 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16- 1948, at 9.40P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-16 1948 to 1-16 1948 and that I last saw h~~er~~ alive on 1-16 1948

Immediate cause of death: Prematurity — Duration 1½ hrs.
Due to:
Due to:
Other Conditions Congenital Atelectasis — 1½ hrs.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Prematurity, Atelectasis

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julian P. Griffin M. D.
Address Balto City Hosp Date signed 21 Jan 48

X

G59543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G59543

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4400 Spring Ave
(c) Hospital or institution: 28-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4400 Spring Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George B. Tracey.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Margaret E.

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.): Oct 4 1862

8. AGE: Years: 85 | Months | Days | If less than one day: hr. min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual Occupation: Retired Contractor.

11. Industry or business:

FATHER
12. Name: John Tracey
13. Birthplace: Carroll Co. Maryland

MOTHER
14. Maiden Name: Mary Richards
15. Birthplace: Carroll Co. Md.

16 (a) Informant: Margaret E. Tracey
(b) Address: 4400 Spring Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-29-48 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville Md.

18 (a) Funeral director: Irving Ryan
(b) Address: 5005 Park Heights Ave

19 (a) JAN 29 1948 (Date rec'd by registrar) (b) Huntington Williams Mills Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26, 1948, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1948 to Jan 26 1948, and that I last saw h[illegible] alive on Jan 26 1947

Immediate cause of death	Duration
Cerebral Hemorrhage.	
Due to Generalized Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julius C. Bleicher M. D.
Address 5356 Reisterstown Rd. Date signed 1/28/48

V S 150

G59544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G59544

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 932. N Charles St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 932 N Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Rosa Franz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 22, 1881

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Designer
11. Industry or business Dress Business

FATHER
12. Name Conrad Franz
13. Birthplace Germany

MOTHER
14. Maiden Name Theresa Lemberg
15. Birthplace Germany

16 (a) Informant Mrs. Cecelia Schnorzkopf
(b) Address 932. N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-30-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Henry Boos
(b) Address 5805 Falls Rd Govans

19 JAN 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26th 1948, at 10 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947, to Jan 26 1948, and that I last saw h[illegible] alive on Jan 26 1948.

Immediate cause of death Cancer of Stomach. Duration 6 mos

Due to Coronary Arteriosclerosis 6 mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. A. Shatard M. D.
Address 1 E. Lexington St Date signed 1/29/48

C59545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. C59545

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 Linden Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK L. MORMANN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Edna M. Myers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1895

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER 12. Name Fred A. Mormann
13. Birthplace Baltimore

MOTHER 14. Maiden Name Lula Scott
15. Birthplace Baltimore

16 (a) Informant Miss Dorothy Schaefer
(b) Address 3719 Wilkens Ave

17 (a) Burial (b) Date thereof 1-30-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore Co. Md.

18 (a) Funeral director Brian Bros
(b) Address 5005 Pk Heights Ave

19 (a) JAN 29 1948 (b) Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1948, at 1:50 A M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary artery disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl V. Ryan M.D.
Medical Examiner

Date signed 1-28-48

X

C59546

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

C59546
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1931 E. 30th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1931 E. 30th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Ruth Ellis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 4, 1914

8. AGE: Years	Months	Days	If less than one day
33			hr. min.

9. Birthplace Warren Ohio
(Town, county, and state)
10. Usual Occupation School Teacher
11. Industry or business C. A. Co. (Brooklyn)

FATHER
12. Name Herbert Ellis
13. Birthplace [illegible]

MOTHER
14. Maiden Name [illegible]
15. Birthplace Merced Co. Cal.

16 (a) Informant Mrs Herbert Ellis
(b) Address 1931 E. 30th St.
17 (a) Burial (b) Date thereof 1-31-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge Memory
Location Baltimore Maryland
18 (a) Funeral director Lewis Bruce
(b) Address 3605 Old Frederick Rd
19 (a) JAN 29 1948 (b) [illegible] for William Schaefer
(Date rec'd by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27, 1948, at 6 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from April 26 1946 to Jan 27 1948.
and that I last saw her alive on Jan 27 1948.

Immediate cause of death, Cancer of breast with numerous metastases — Duration: 1 year 9 months
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harry D. McCarty M. D.
Address 57 W. Preston Date signed 1/28/48

V S 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. G59547

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 Lemmon St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Howard J. Counabaugh

3 (b) If veteran, name war: WW #1

3 (c) Social Security Account No. 705-10-2525

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	WIDOWED

6 (b) Name of husband or wife: ANNIE MARIE (JONES)
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) JAN 24, 1887

8. AGE: Years	Months	Days	If less than one day
61		✓	hr. min.

9. Birthplace: BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation: MECHANIC.
11. Industry or business

FATHER
12. Name: DANIEL COUNABAUGH.
13. Birthplace: MARYLAND

MOTHER
14. Maiden Name: MARGARITE CLEARY
15. Birthplace: ENGLAND

16 (a) Informant: MRS. LESLIE POFF
(b) Address: SHORE ACRE RD. ARNOLD, MD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1 29 48 (month) (day) (year)
(c) Cemetery or crematory: CEDAR HILL
Location: RITCHIE HIGHWAY

18 (a) Funeral director: JOHN F. DENNY, INC
(b) Address: 715 LIGHT ST -30

19 (a) JAN 29 1948 (Date rec'd by registrar) (b) Huntington Wilt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1948, at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Carcinoma of Lung.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: George G. Merrill M.D. Medical Examiner.
Date signed 1/27/48

VS 191

G59548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

G59548 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General 25-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore-Curtis Bay (If outside city limits write RURAL and give town)
(d) Street No. 429 Church St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME WILLIAM COOK

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) SEPT. 23, 1928

8. AGE: Years 19 | Months 4 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace HOWARD CO. (Town, county, and state)

10. Usual Occupation MACHINIST.

11. Industry or business

FATHER
12. Name GLOYD T. COOK
13. Birthplace FREDERICK CO, MD.

MOTHER
14. Maiden Name RUTH H. HARRISON
15. Birthplace BALTIMORE, MD.

16 (a) Informant MR GLOYD T. COOK
(b) Address 1428 CHURCH ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1 30 48 (month) (day) (year)
(c) Cemetery or crematory MT OLIVET.
Location FREDERICK RD

18 (a) Funeral director JOHN F. DENNY, INC
(b) Address 715 LIGHT ST.

19 (a) JAN 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/28/48 19 ____, 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon Monoxide Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/28/48 9 A.M.
(b) Where did injury occur? 429 Church St Flat
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? NO
(d) Means of injury burned on gas burners

23. Signature John R Weaver M.D. Medical Examiner.
Date signed 1/28/48

VS 181

G59549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G59549 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3642 Hickory Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3642 Hickory Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME James R. Meade

3 (b) If veteran, name war —
3 (c) Social Security Account No. 212-09-4963

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ida M. Meade
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10-1876

8. AGE: Years	Months	Days	If less than one day
71	10	17	hr. min.

9. Birthplace Baltimore Co. Md. (Town, county, and state)
10. Usual Occupation Machinist (Foreman)
11. Industry or business Retired 6 years

FATHER
12. Name James A. Meade
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Ryan
15. Birthplace Maryland

16 (a) Informant James R. Meade
(b) Address 525 Sudbrook Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 30-1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) JAN 29 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27 1948, at 1-40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-44 to 1946, to Jan 27 1948, and that I last saw h alive on Jan 27 1948.

Immediate cause of death	Duration
Chr. Valvular Heart disease (Mitral insufficiency)	1944
Due to	
Due to Chr. Interstitial nephritis	1944
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Paul Brown M. D.
Address 1163 N. North Ave. Date signed 1/28/48

VS. 159

659550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1939

659550 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3502 Clifton Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 703 N. 36th Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Grace Shaffer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Theodore Harry Shaffer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13-1882

8. AGE: Years 65 | Months 11 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Charles H. Quill
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Langdon
15 Birthplace Maryland

16 (a) Informant Charles Edward Shaffer
(b) Address 3509 Roland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 29-1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) Jan 29 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26 1948 at 6 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from November 1947 to Jan. 26 1948, and that I last saw her alive on Jan 26 1948.

Immediate cause of death: Congestive Heart Failure — Duration: 2 months
Due to: Hypertensive Cardio-Vascular Disease — ?
Due to:
Other Conditions: Cerebral Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Fuesting M. D.
Address 11 E. Chase St. Date signed 1-28-48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59551

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1948

Registered No. G59551

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3556 Buena Vista Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3556 Buena Vista Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Fannie May Pearce

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: George A. Pearce
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): July 18-1876
8. AGE: Years 71 | Months 6 | Days 10 | If less than one day: hr. min.
9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: At Home
11. Industry or business:

FATHER
12. Name: Charles R. Hobbs
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Fannie Myers
15. Birthplace: Maryland

16 (a) Informant: George A. Pearce
(b) Address: 3556 Buena Vista Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan. 31-1948 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Park
Location: Baltimore Co. Maryland

18 (a) Funeral director: Burgee Funeral Home
(b) Address: 3631 Falls Road

19 (a) JAN 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 28-1948, at 11:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Jan 28 1948, and that I last saw h[illegible] alive on Jan 28 1948.

Immediate cause of death: Coronary Thrombosis / Arteriosclerosis / CVD / Decomp

Duration: 1 day

Due to:

Due to:

Other Conditions: Hypertension

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Fannie M. Hunnicutt M. D.
Address 3711 Falls Rd Date signed 1-29-48

VS 150

059552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. 059552

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 19-
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? ----- (Yes or No)
If yes, name country ---------

3 (a) FULL NAME William T Bennett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Rose ------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ---------

8. AGE: Years	Months	Days	If less than one day
About 70	---	--	--hr. ---min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business -------

FATHER
12. Name Not obtainable
13. Birthplace " "

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant S. R. Mears
(b) Address 805 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) JAN 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1948, at 2.55 P.M.

21. I certify that I took charge of the remains described above, held an Ing Ex Onsp thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X] accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William T Kelsick M.D.
Medical Examiner.
Date signed 1/27/48

VS 181

659553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 659553

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 458 E. Cross St.
(c) Hospital or institution: 24

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 458 E. Cross St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Edna E. Leitch

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Marriott C. Leitch

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1909

8. AGE: Years 38 | Months 1 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Elmer M. Selby
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Elizabeth M. Cooke
15. Birthplace Baltimore, Maryland

16 (a) Informant Marriott C. Leitch (Husband)
(b) Address 458 E. Cross St.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Thurs Jan. 29, 1948 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Baltimore Co., Maryland

18 (a) Funeral director C. Howard Evans
(b) Address 1400 S. Charles St.

19 (a) JAN 29 1948 (Date rec'd by registrar) Baltimore, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mon. Jan. 26 1948, at 7:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1948 to Jan 26 1948, and that I last saw h alive on Jan 22 1948.

Immediate cause of death	Duration
Coronary Thrombosis	2 days
Due to Chronic Nephritis & Hypertension	Chron
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? (
(e) Means of injury

23. Signature C. Howard Evans M.D.

Address 1400 S. Charles St. Date signed 1/28/48

VS 150

G59554

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G59554

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3728 Elm Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3728 Elm Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katherine Brennan

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife George Brennan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20, 1863

8. AGE: Years 84 | Months 2 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Brown
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Manning
15. Birthplace Ireland

16 (a) Informant Mrs Agnes Loftus
(b) Address 3728 Elm Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-30-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md.

18 (a) Funeral director Frank W. Serf
(b) Address 814 West 36 St.

19 (a) JAN 29 1948 (Date rec'd by registrar) (b) Carrington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to Jan 27 1948, and that I last saw h. alive on Jan 27 1948

Immediate cause of death: Hypertensive CVDC — Decomp — Duration 3 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laurence J. Linnard M. D.
Address 3[illegible] Fallsway Date signed 1-29-48

VS 150

X

G59555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G59555

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 808 Brooke Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 yrs 1
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 808 Brooke Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Solomon Coplon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Bertha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 10th, 1861

8. AGE: Years	Months	Days	If less than one day
86 (87)	7	29	hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15 Birthplace Russia

16 (a) Informant Bertha Coplon
(b) Address 808 Brooke Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-30-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) JAN 29 1948 (Date rec'd by registrar) (b) Huntington Willis (Registrar) M. D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-29- 1948, at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24 1948 to Jan 29 1948, and that I last saw h[illegible] alive on Jan 28 1948

Immediate cause of death Coronary thrombosis — Duration 5 days
Due to Arteriosclerosis — 5 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J Frederick Low M. D.
Address Temple Garden 9th Date signed 1-29-48

VS 150

X

G59556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

G59556 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — D.o.H
(b) Street address
(c) Hospital or institution: West Balto General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs 12

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3571 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harris Saperstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: a | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: ~~Ida~~ Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 67 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: retired

11. Industry or business

FATHER
12. Name: Isaac
13. Birthplace: Russia

MOTHER
14. Maiden Name: not known
15. Birthplace: Russia

16 (a) Informant: Isaac Blank
(b) Address: 4024 Boarman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-48 (month) (day) (year)
(c) Cemetery or crematory: Shaarei Tefiloh
Location: Windsor Mill Rd

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 2100 Eastern Ave

19 (a) JAN 29 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/27 1948, at 11:20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: G. J. Schmeisser M.D. (Medical Examiner)
Date signed 1/27/48

VS 191

X

C59557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. C59557

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: Mercy Hospital 6-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2326 E. Balto St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Walder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 59 | Months | Days | If less than one day: hr. min.

9. Birthplace: Balto Md
(Town, county, and state)

10. Usual Occupation: Tailor

11. Industry or business

FATHER
12. Name: Wolfe
13. Birthplace: Russia

MOTHER
14. Maiden Name: Mollie
15. Birthplace: Russia

16 (a) Informant: Lillian Walder
(b) Address: 2326 E Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-30-48 (month) (day) (year)

(c) Cemetery or crematory
Location: Hebrew Friendship

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 260 Eutaw Place

19 (a) JAN 29 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 1948, at 3:50 P.M.

21. I certify that I took charge of the remains described above, held an Inquest (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Kelfrich M.D.
Medical Examiner.

Date signed 1/28/48

G59558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59558

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-1b
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 4613 ParkHeights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH GLICK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Aaron

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Laib Leiberman
13. Birthplace Russia

MOTHER
14. Maiden Name Toba ?
15. Birthplace Russia

16 (a) Informant Mr Hyman Glick
(b) Address 3500 Taney Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan, 29, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave Rosedale

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) JAN 29 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 1948, at 3.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1948 to Jan 27th 1948, and that I last saw her alive on Jan 27th 1948.

Immediate cause of death Heart failure, precipitated by

Due to Fracture of hip

Due to Senility

Other Conditions Arterio-sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Jan 27 1948 at 10 A.M.
(c) Where did injury occur? 4613 Park Heights Ave Baltimore Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell to floor at home

23. Signature Harris A Levin M. D.
Address 1128 N Bigelow Date signed 1/29/48

Howard J. Bruenger, M.D.

VS 190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59559

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G59559

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 816 Ostend st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 + 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 816 Ostend St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Gray

3 (b) If veteran, name war

3 (c) Social Security Account No. 1/25/48

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Washington, D.C. (Town, county and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Frances Ferguson

15. Birthplace Wash., D. C.

16 (a) Informant Frances Ferguson

(b) Address 816 Ostend St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29, 1948 (month) (day) (year)

(c) Cemetery or crematory Balto. Nat. Cem.

Location Baltimore, Md

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brantley ave

19 (a) JAN 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1948, at 5:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1947 to Jan 25 1948, and that I last saw him alive on Jan 23 1948.

Immediate cause of death	Duration
Congestive Heart Failure	2 mos.
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert L. Moseley, Jr. M.D.

Address 2024 Madison Ave Date signed 1/28/48

Moseley X

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 59560

59560
AB-114638

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Information as to age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 2-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 34yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 E. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Dabich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mildred (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6- 1886

8. AGE: Years 61 | Months 3 | Days 21 | If less than one day hr. min.

9. Birthplace Yugoslavia (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

MOTHER / FATHER

12. Name George (D

13. Birthplace Yugoslavia

14. Maiden Name Stella (D

15. Birthplace Yugoslavia

16 (a) Informant Records-Baltimore City Hospita

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 30-48 (month) (day) (year)

(c) Cemetery or crematory Holy Trinity Russian

Location Stoney Run, Md

18 (a) Funeral director John A Grebinschyk Jr

(b) Address 423 S. Paca St

19 (a) JAN 29 1948 (Date rec'd by Registrar) (b) Interment for Williams, Md Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27 19 48 at 8.[illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-20- 19 47 to 1-27 19 48 and that I last saw h im alive on 1-27- 19 48

Immediate cause of death: Acute Congestive Heart Failure — Duration: 1 days

Due to: Arteriosclerotic Heart Disease — Duration: years

Due to: Basal tissue — Duration: weeks

Other Conditions: Hemanthoids, Int. & External — Duration: weeks

(Include pregnancy within 3 months of death)

Date of operation Jan 27, 48

Major findings of operation: Int. and Ext. Hemanthoids, Basal tissue

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Rush E. Nitterville M. D.

Address Balt. City Hosp. Date signed Jan 27 48

659561

GM. 107829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V61

Registered No. 659561

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Year

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 256 N. Exeter (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Carlotta Or Joseph Culatta

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March- 19- 1872

8. AGE: Years	Months	Days	If less than one day
75	10	4	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Culotta ?

13. Birthplace Italy

MOTHER

14. Maiden Name ?

15. Birthplace Italy

16 (a) Informant Records B lto. City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 30 1948 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Blain Rd

18 (a) Funeral director Joseph Farace Inc

(b) Address 2413 Greenmount Ave

19 (b) JAN 29 1948 (Date rec'd by registrar) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1- 23 - 1948 at 10.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-22-1947 to 1-23-1948. and that I last saw him alive on Jan. 23 - 1948.

Immediate cause of death

Possible Coronary Insufficiency — Duration: 1 day

Due to Arteriosclerosis Generalized — Duration: yrs

Due to — Duration: mos

Other Conditions Diabetic Mellitus — Duration: yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. D. Robinson Jr

Address Balt. City Hosp Date signed 1/28/48 M. D.

VS 150

9da

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

659562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 659562

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore-28 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Maple Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Coe

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1948

8. AGE: Years — | Months — | Days 2 | If less than one day 18 hr. 56 min.

9. Birthplace St. Agnes Hosp. Balto. Md. (Town, county and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name George T Coe
13. Birthplace Catonsville, Md.

MOTHER
14. Maiden Name Ruth Sebastell
15. Birthplace Peach Co. Georgia

16 (a) Informant George T. Coe
(b) Address 2 Maple Ave. Catons. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Easton Sons and
(b) Address 608 Frederick Ave. Catons

19 (a) Attested by Walter for Williams, M.D. Registrar
(b) Date received by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/27 1948 at 6:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/24 1948 to 1/27 1948 and that I last saw h/m alive on 1/27 1948

Immediate cause of death Intracranial Hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jose A. Valderas M. D.
Address St. Agnes' Hosp. Date signed 1-28-48

VS 150

659563 Med. Exams. Case 249-652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

146c

Registered No. 659563

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 48-01736
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 629 So. Charles St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace (Dorsey) Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-17-1917

8. AGE: Years 30 | Months 11 | Days 9 | If less than one day hr. min.

9. Birthplace Williamston, S.C. (Town, county, and state)

10. Usual Occupation Operator

11. Industry or business

FATHER 12. Name Alonzo Madison
13. Birthplace S.C.

MOTHER 14. Maiden Name Jane Blackman
15. Birthplace S.C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 31-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Samuel Staggs
(b) Address 142 Woodyear

19 (a) JAN 29 1948 (Date rec'd by registrar) (b) Huntington Willia[illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-26-1948, at 5:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-26-1948 to 19 , and that I last saw her alive on 1-26-48

Immediate cause of death Shock — Duration 24 hr

Due to Hemorrhage post partum — 3 hr

Due to

Other Conditions Pregnancy delivered
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Nesto-Long, M.D.
Address Johns Hopkins Hosp Date signed 1-27-48

150 Medical Exams Case

For [illegible] Kammerer, M.D.
Howard Cummings, M.D.

G59564

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 559

Registered No. G59564

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Elmhurst Home 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) ?
(e) Length of stay in Baltimore (yrs., mos., or days) abt 10 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2121 Penna. Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Soo Hoo Hong

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: Yellow
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Ching Shee
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) June-6-1868

8. AGE: Years 79 | Months 7 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace California (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Laundryman

FATHER
12. Name Not Known
13. Birthplace China

MOTHER
14. Maiden Name Not Known
15. Birthplace China

16 (a) Informant Mrs. Soo Hoo Poy (son)
(b) Address 2121 Penna. Ave. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan-30-48 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn, Md.

18 (a) Funeral director Stewart & Monument Company
(b) Address 108 W. North Ave, City

19 (a) Kenneth Farrington for Wilbur (b) Registrar (Signature of registrar)

JAN 29 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28, 1948, at 1 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 25, 1948 to Jan 26, 1948, and that I last saw him alive on ____ 19____.

Immediate cause of death: Respiratory failure.
Due to: Metastatic Carcinoma from Carcinoma of left Antrum
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Abram Goldman M. D.
Address 206 S. Gilmor St Date signed 1.29.48

VS 150

X

C59565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 483a

Registered No. C59565

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. & Calvert Sts
(c) Hospital or institution: Union Memorial Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3307- 1/2 Chestnut St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME TOM WING

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: Chinese

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife: Single

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1889

8. AGE: Years 59 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace China (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Laundryman

FATHER
12. Name Not Known
13. Birthplace China

MOTHER
14. Maiden Name Not Known
15. Birthplace China

16 (a) Informant Mr. Hom Sing (cousin)
(b) Address 316 Park Avenue, City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan-29-48 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn, Md.

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Avenue, City.

19 (a) JAN 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27, 1948, at 5.35 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage, Spontaneous.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Rogers M.D. Medical Examiner
Date signed 1-27-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

659566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. 659566

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mercy Hospital
(c) Hospital or institution: Calvert + Saratoga Sts.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 12 - 2
(e) Length of stay in Baltimore (yrs., mos., or days) 38 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. Homewood Apts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Frank A. Bushey Bannister

3 (b) If veteran, name war None

3 (c) Social Security Account No. —

4. Sex M.

5. Color or race Wh.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lucille W Bannister

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) ~~12-28-1870~~ 12/28/1870

8. AGE: Years 77 | Months 1 | Days 1 | If less than one day ..... hr. ..... min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Worthington H. ~~Harvey~~ Bannister
13. Birthplace Ohio

MOTHER
14. Maiden Name Francis V. Bushey
15. Birthplace ~~Md.~~ probably Ohio

16 (a) Informant: Mrs. Lucille W. Bannister (wife)
(b) Address Homewood Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 31/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Maryland

18 (a) Funeral director Edmonds Mowen Company
(b) Address 128-W-North Ave. Baltimore, Md.

19 JAN 29 1948 (Date rec'd by registrar) Timothy O'Connor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 1948, at 1:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-28 1947, to 1-29 1948, and that I last saw h.im alive on 1-29 1948.

	Duration
Immediate cause of death Hypostatic pneumonia, acidosis, cardiac decompensation	
Due to Carcinoma of liver	5 months
Due to	
Other Conditions Arteriosclerotic heart disease + generalized arteriosclerosis. (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Lohman M. D.
Address Mercy Hospital Date signed 1-29-48

VS 150

G59567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G59567

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2304 Essex
(c) Hospital or institution: 1-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2304 Essex Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME THEODOZIA CAPAK

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband ~~of~~ Joseph Capak
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Dec ? 1887

8. AGE: Years	Months	Days	If less than one day
60	1		hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jacob Gawrys
13. Birthplace ?

MOTHER
14. Maiden Name Maryanna Kaczmarek
15. Birthplace ?

16 (a) Informant Joseph Capak
(b) Address 2304 Essex street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-31-48 (month) (day) (year)
(c) Cemetery ~~cemetery~~ St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann st

19 (a) JAN 29 1948 (Date rec'd by registrar) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/28/48 19 , at 4:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Weis M.D. Medical Examiner.
Date signed 1/28/48

VS 151

059568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 059568

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11-3
(c) Hospital or institution: 708 Tyson St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 708 Tyson St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mary Perry
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Fem | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: widower
6 (b) Name of husband or wife: Nick Perry
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 15 1883
8. AGE: Years: 64 | Months: -5 | Days: -8 | If less than one day: hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laundress
11. Industry or business

FATHER
12. Name Don't Know
13. Birthplace Va

MOTHER
14. Maiden Name Mary Morris
15. Birthplace Maryland

16 (a) Informant Harry D Madison
(b) Address 879 Tyson St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location
18 (a) Funeral director A. Hasten Scott
(b) Address 708 Tyson St
19 (a) JAN 29 1948 (Date received by registrar) Transit for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23, 1948, at 12 M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 1948 to Jan 23 1948, and that I last saw h[illegible] alive on Jan 22, 1948.

Immediate cause of death: Cerebral Hemorrhage
Due to: Senility
Due to: Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature D. Grant Scott
Address 354 N. Bidleton Date signed 1-26-48 M. D.

VS 3

Copies are not acceptable. Typewriter must be used in filling in this certificate. Please write plainly with pen and ink.

G59569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G59569 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3416 Holmes Ave
(c) Hospital or institution: 13-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3416 Holmes Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Belle Kafka

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1880

8. AGE: Years	Months	Days	If less than one day
67	1	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Joseph Kafka
13. Birthplace Austria

MOTHER
14. Maiden Name Mary Lauber
15. Birthplace Austria

16 (a) Informant Mrs. Harry Fay
(b) Address 3416 Holmes Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/30/48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Sinai Memorial Chapel
(b) Address 20 N. Eutaw Place

19 (a) (Date received by Local Registrar) (b) Huntington Woods, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28 1948, at 3:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1947, to Jan 28 1948, and that I last saw her alive on Jan 28 1948.

Immediate cause of death: Cardio-Respiratory Failure — Duration

Due to Primary Adeno Carcinoma of Ovary

Due to Generalized Abdominal Carcinomatosis.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Applefeld M.D.
Address 2511 Reisterstown Rd. Date signed 1/28/48

VS 150

DR. PILLSBURY

659570

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

659570 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 811 E. 22ND ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 811 E 22ND ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ella M. Spicer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Wm. Spicer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. C. Cavek
13. Birthplace Balto.

MOTHER
14. Maiden Name Loretta Von Upperman
15 Birthplace Balto.

16 (a) Informant Mr. Wm. Spicer
(b) Address 811 E. 22nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location

18 (a) Funeral director Wiedefeld & Son
(b) Address Greenmount & 22nd

JAN 29 1948 (Date rec'd by registrar) (b) Registrar
Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-26-48 19 , at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 24 1948 to Jan. 26 1948, and that I last saw her alive on Jan. 26 1948.

Immediate cause of death Myocardial insufficiency. Renal insufficiency. — Duration 1 day

Due to Generalized carcinomatosis. —

Due to Carcinoma of the breast at least a year. —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold C. Pillsbury M.D.
Address 31 E. North Av. Date signed 1/28/48

G59571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G59571 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The coroner is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20A
(e) Length of stay in Baltimore (yrs., mos., or days) 20A

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write Rural and give town)
(d) Street No. 729 W. Fayette Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John D. Fitez

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
Male	W	divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 3, 1883

8. AGE: Years	Months	Days	If less than one day
64	11	24	hr. min.

9. Birthplace Frederick County Md. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER 12. Name John D. Fitez

13. Birthplace Md.

MOTHER 14. Maiden Name Amanda Whitmore

15. Birthplace Md

16 (a) Informant Charles W. Brown

(b) Address 510 McCabe ave.

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 1/30/48 (month) (day) (year)

(c) Cemetery or crematory Simpson's

Location Simpsons Md

18 (a) Funeral director Wilson Cook & Co

(b) Address 1211 Eutaw Pl

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 29 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/27/48 19 at 10:45 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home or farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D. Medical Examiner

Date signed 1/28/48

VS 191

G59572 W25-137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

G59572 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 307 Whitridge Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 - 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 307 Whitridge Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles S. Chalk.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Mary Chalk

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1857

8. AGE: Years 90 | Months 6 | Days 27 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Charles B. Chalk
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary E. McKeever
15. Birthplace Maryland

16 (a) Informant Wm. L. Chalk
(b) Address 307 Whitridge Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29/48 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden, Md.

18 (a) Funeral director Thanover & Sonovan
(b) Address 3415-17 Chestnut Ave.

JAN 29 1948 (Date rec'd by registrar)

Registrar for Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26, 1948, at 12 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1945 to Jan 26 1948 and that I last saw h[illegible] alive on Jan 26 1948

Immediate cause of death: (a) Cerebral Hemorrhage — Duration: widow

Due to: (b) —

Due to: (c) —

Other Conditions: Arteriosclerosis — widow
Chronic Nephritis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 112 W. 25th St. Date signed 1-28-48

VS 150

959

G59573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

G59573 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 W. Barre St.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 W Barre St., (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Annie Fraga Frazier

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife William Frazier
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) 6/12/1910

8. AGE: Years 37 | Months 7 | Days 13 14 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Domestic (maid)
11. Industry or business University Hospital

FATHER
12. Name John Watkins
13. Birthplace Va.

MOTHER
14. Maiden Name Anna Bremer
15. Birthplace Md.

16 (a) Informant William Frazier
(b) Address 504 W Barre St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-31-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn St
Location Balto City

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W. Montgomery St.,

19 (a) (Date received by registrar) (b) Registrar

JAN 28 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/26/48 19 , at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5 1948 to 1/26 1948, and that I last saw her alive on 1/26 1948.

Immediate cause of death Acute Lobar Pneumonia — Duration 4 Wks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Frazier M. D.
Address 1422 Lee Date signed 1/28/48

VS 150

G59574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓467

G59574 Registered No.

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BLANKS RESERVED FOR SECOND

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 909 Sharp St
(c) Hospital or institution: 231
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 909 Sharp St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Florence Bertina Spriggs

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/4/1877

8. AGE: Years 70 | Months 9 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James H. Hill
13. Birthplace Md.

MOTHER
14. Maiden Name Eliza Lovell
15. Birthplace Va.

16 (a) Informant Vernon Hill (S)
(b) Address 229 W Hamburg St

17 (a) Burial (b) Date thereof 1-28-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location A. A. Co., Md.

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) (Date received by registrar) (b) Huntington Willis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/26/48 19 40, at 12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 17 19 47 to Jan 26 19 48 and that I last saw h[illegible] alive on Jan 26 19 48.

Immediate cause of death

Duration

Carcinoma of rectum — 4 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H H White

Address 154 Huntington Ave Date signed 1/29/48 (M. D.)

VS 150

G59575 BELZNER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161

Registered No. G59575

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1901 E. 28th St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-6
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1901 E. 28th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis J. Belzner

3 (b) If veteran, name war —
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Married

6 (b) Name of husband or wife Louisa A.
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr) May 6 187?

8. AGE: Years	Months	Days	If less than one day: hr.	min.
70	8	22		

9. Birthplace Balto Md
(Town, county and state)
10. Usual Occupation Chief Clerk Recorder
11. Industry or business State of Md

FATHER
12. Name ? Belzner
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace " (wife)

16 (a) Informant Mrs Louisa Belzner
(b) Address 1901 E 28th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/48 (month) (day) (year)
(c) Cemetery or crematory Druid Hill Park
Location Druid Lane

18 (a) Funeral director L. Hegmann & Son
(b) Address 6067 Harford Rd

19 (a) JAN 29 1948 (Date received by registrar) Lucretia Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27. 1948. at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to Jan 27 1948. and that I last saw him alive on Jan 27 1948.

Immediate cause of death Cardiac Failure — Duration
Due to Coronary Thrombosis
Due to Arteriosclerosis
Other Conditions Pulmonary Infarction, Diabetes
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Crulcrest
Address 2116 W Pratt Date signed 1/28/48 M. D.

VS 150

94a

G59576 Barnicle ✓ 46 B

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Register (No.) G59576

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1845 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME NAOMI SEISS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Seperated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6 - 1875

8. AGE: Years 72 | Months 9 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Rinehart

13. Birthplace Unknown

MOTHER 14. Maiden Name "

15. Birthplace "

16 (a) Informant Mrs. Ida Hilliary

(b) Address 2513 W. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 30 1948 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem.

Location Balto.

18 (a) Funeral director Jeannie Cook Dyer

(b) Address 1600 W. North Ave

19 (a) JAN 29 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27, 1948, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 22 1948 to Jan 27 1948, and that I last saw her alive on Jan 27, 1948.

Immediate cause of death Carcinoma of Stomach — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank J. Brady M. D.

Address Md. Gen. Hosp. Date signed 1-27-48

VS 150

G59577

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G59577

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1125 Forrest st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 Forrest St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Hurst Busick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Ida Louise Busick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 7th 1867

8. AGE: Years	Months	Days	If less than one day
80	1	20	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Machinist

FATHER
12. Name Joshua Busick
13. Birthplace Md.

MOTHER
14. Maiden Name Kate Boyer
15. Birthplace Md.

16 (a) Informant Ida L. Busick
(b) Address 1125 Forrest St

17 (a) Burial (b) Date thereof 1/30/48
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 Fountain Ave Baltimore, Md.

19 JAN 29 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27th 1948, at 11:20 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 5 1947, to 27 Jan 1948, and that I last saw h~~im~~ alive on 26 Jan 1948.

Immediate cause of death myocardial failure — Duration 1 week

Due to old age

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Silverfed M. D.
Address 714 E. Preston Date signed 28 Jan 48

Funeral Exes

VS 159

Please write plainly, with pen and ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G59578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G59578
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Home For Incurables
(c) Hospital or institution: 700 West 40th St

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Greenway Apt Charlesand 34 St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Stewart Isaac

3 (b) If veteran, name war W | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Roberta Lee Gantt
6 (c) If alive, give age / years

7. Birth date of deceased (mo., day, yr.) 1870 4 - 4

8. AGE: Years 77 | Months 9 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace Prince Frederick Md.
(Town, county, and state)

10. Usual Occupation Retired
11. Industry or business C

FATHER
12. Name Virgil Gantt
13. Birthplace Prince Frederick - Md -

MOTHER
14. Maiden Name Mary Jane Stewart
15. Birthplace Unknown

16 (a) Informant Home For Incurables
(b) Address 700 W. 40th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Pellegrini & Son
(b) Address 1217 E Fayette St

19 (a) JAN 29 1948 (Date rec'd by registrar) (b) Hunting for Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1948, at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from January 16 1948, to Jan 29 1948, and that I last saw h alive on Jan 28 1948.

	Duration
Immediate cause of death Coronary Thrombosis	6 hours
Due to Arteriosclerotic Cardio Vascular Disease	10 years
Due to	
Other Conditions Pernicious Anemia	2 years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Arnold Wolf M. D.
Address 11 E Chase ST Date signed 1/29/48
Baltimore Maryland

Physicians: please write the causes of death clearly and legibly. Be sure that the statements are correct are is especially important.

G59579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

Registered No. G59579

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 3900 Foster Ave.
(c) Hospital or institution: home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-9
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 3900 Foster Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Florence Ries

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: -

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John J.

6 (c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Aug. 23, 1879

8. AGE: Years: 68 | Months: 5 | Days: 4 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: Louis Reinhardt
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Emma Harrison
15 Birthplace: Baltimore

16 (a) Informant: John J. Ries
(b) Address: 3900 Foster Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 30-48 (month) (day) (year)
(c) Cemetery or crematory: PARKWOOD
Location: PARKVILLE MD.

18 (a) Funeral director: Wm. Cook, Inc.
(b) Address: 1217 St. Paul Street
Huntington Williams, Mgr.

19 (a) JAN 29 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 27 1948 at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 1946, to Jan 27 1948, and that I last saw her alive on Jan 27 1948.

Immediate cause of death: Diabetes Mellitus — Duration: 1946
Due to: Arteriosclerotic C.V. Disease — 1946
Due to: Chronic Nephritis — 1946
Due to: Chronic Myocarditis — 1946
Due to: Acute Coronary Occlusion — 1-27-48

Other Conditions: None
(Include pregnancy within 3 months of death)

Date of operation: -
Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Eva Schumacher M. D.
Address: 842 Edmondson Ave Date signed 1-29-48

VS 150

G59580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

No. 1240 / 131a

G59580 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1742 E. Lombard st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1742 E. Lombard st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Ofsian

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband ~~or wife~~: Charles Ofsian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1883

8. AGE: Years 64 | Months 6 | Days | If less than one day hr. min.

9. Birthplace Lithuania
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name Joseph Markabich
13. Birthplace

MOTHER
14. Maiden Name Elizabeth
15. Birthplace

16 (a) Informant Elizabeth Forrest
(b) Address 1742 E. Lombard st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st

19 (a) JAN 29 1948 (Date rec'd by registrar) (b) Funeral for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28th 1948, at 6:41 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1941, to January 28 1948, and that I last saw her alive on January 28 1948.

	Duration
Immediate cause of death: Cerebral Hemorrhage	2 days
Due to: Cardio-Vascular-Renal Hypertensive Disease	6 years
Due to: Arteriosclerosis	6 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Michael J. Daunch M. D.
Address 1W. Chase Ave Date signed 1/29/48

VS 150

G59581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1090

Registered No. G59581

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1125 Forrest St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 1125 Forrest St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME J. Louise Busick

3 (b) If veteran, name war W

3 (c) Social Security Account No. NONE

4. Sex Female

5. Color or race White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband Richard Hurst Busick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 2. 1868

8. AGE: Years 79 | Months 10 | Days 2. | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER 12. Name George Blakey

13. Birthplace Md.

MOTHER 14. Maiden Name Harriett Scarborough

15 Birthplace Md.

16 (a) Informant Mrs. Mattie Howell

(b) Address 1125 Forrest st.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 1/30/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Druid Ridge

Location Pikesville Md.

18 (a) Funeral director William Cook Inc.

(b) Address 127 St. Paul st

19 (a) JAN 29 1948 (Date received by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28th 1948, at M

21. I certify that death occurred on the date above stated, that I attended deceased from 26 Jan 1948 to 28 Jan 1948 and that I last saw her alive on 28 Jan 1948.

Immediate cause of death	Duration
(a) Coronary left ventricular failure	1 Day
Virus Pneumonia	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Samuel Lilienfeld M. D.

Address 714 E. Preston Date signed 29 Jan 48

LILIENFELD

VS 150

659582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1478

Registered No. 659582

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 26
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name town)
(d) Street No. 4618 Bowleys Lane
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth A. Healy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband: Austin J. Healy Jr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec 21st 1916

8. AGE: Years: 31 | Months: 1 | Days: 7 | If less than one day: hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: Airey
13. Birthplace

MOTHER
14. Maiden Name: Unknown
15. Birthplace

16 (a) Informant: Austin J. Healy Jr.
(b) Address 4618 Bowleys Lane

17. Burial
(Burial, cremation, or removal)
(b) Date thereof 1/31/48
(month) (day) (year)
(c) Cemetery or crematory: Holy Cross
Location: Baltimore Md

18 (a) Funeral director: Williams Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) JAN 29 1948
(Date rec'd by registrar)
(b) Burial Permit No.

MEDICAL CERTIFICATION 45

20. DATE OF DEATH January 28, 1948, at 11 A M

21. I certify that I took charge of the remains described above, held an Autopsy & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Peritonitis
Due to Incomplete Abortion
Acute endometritis with retained placenta (full term)
Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Pugh M.D.
Medical Examiner.
Date signed 1/28/48

VS 151

C59583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C59583

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St & Linden Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 27

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 Hollywood Ave & Harwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie St. Clair

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30 1869

8. AGE: Years	Months	Days	If less than one day
78	9	28	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Francis M St Clair
13. Birthplace Md

MOTHER
14. Maiden Name Mary Wingate
15. Birthplace

16 (a) Informant Lloyd St Clair
(b) Address 617 Hollywood Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Md
18 (a) Funeral director Wilson & Dye
(b) Address 1219 E Fort Ave
19 (a) JAN 29 1948 (b) Huntington Willis Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Jan 1948, at 7:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 28 Jan 1948 to 28 Jan 1948 and that I last saw h[illegible] alive on 28 Jan 1948.

Immediate cause of death	Duration
Cardiac failure	1 day
Due to Arteriosclerotic cardiovascular disease	15 yrs
Due to	
Other Conditions Bronchopneumonia, acute	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. James Hunt M. D.
Address Maryland General Hosp Date signed 1/28/48

VS 150

X

C59584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. C59584

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1012 McKean Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 McKean Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Daniel Scott

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	widower

6 (b) Name of husband or wife Rosie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-4-1848

8. AGE: Years	Months	Days	If less than one day
51	6	24	hr. 7/4/96 min.

9. Birthplace Port Deposit Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jacob Scott
13. Birthplace Md.

MOTHER
14. Maiden Name Mckean
15. Birthplace ?

16 (a) Informant Ruth Harrison
(b) Address 1012 Mc Ekean Ave

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 1-31-48 (month) (day) (year)
(c) Cemetery or crematory Westernard Stan
Location Balto. Co.

18 (a) Funeral director Samuel W. Sullivan Jr
(b) Address 1011 N. Arlington Ave Balto Md

19 JAN 29 1948 (Date received by registrar) (Signature of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 1948, at 8 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28 1948, to Jan 28 1948, and that I last saw h[illegible] alive on Jan 28 1948

Immediate cause of death	Duration
Coronary Occlusion	
Due to Generalized Arteriosclerosis	Sept 1947
Due to	
Other Conditions Myocardial Insufficiency (include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address 7227 Fulton Ave Date signed 1/28/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59585

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH V46E

Registered No. G59585

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 227 S. Madeira Street
(c) Hospital or institution: 1-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 227 S. Madeira Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Wujek Or Walter Wuyek

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mary Wujek
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) May 31 1896

8. AGE: Years 52 | Months 7 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Baltimore City Park Police

11. Industry or business

FATHER 12. Name Frank Wujek
13. Birthplace Poland

MOTHER 14. Maiden Name Jozefa Wojciechowski
15. Birthplace Poland

16 (a) Informant Mrs. Mary Wujek Wife
(b) Address 227 S. Madeira Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-31-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore, County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) Jan 29 1948 (b) Filed by Registrar Kenneth Worthington

MEDICAL CERTIFICATION 1250

20. DATE OF DEATH Jan 27 1948, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-18 1947 to 1/27 1948, and that I last saw h[illegible] alive on 1/27/ 1948.

Immediate cause of death	Duration
Metastasis from adeno carcinoma Colon	8 mo.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 4/28/47
Major findings of operation: Metastasis to ribs.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Kenneth Mortimer M. D.
Address 2906 St. Paul St Date signed 1/29/48

VS 150

C59586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C59586

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Odenton
(If outside city or town limits, write RURAL and give town)
(d) Street No. Cor. Ft. Meade & Millersville Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Redmiles, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 15, 1869

8. AGE: Years	Months	Days	If less than one day
78	11	17	hr. min.

9. Birthplace Dawin, Prince George County, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name William Redmiles, Sr.
13. Birthplace Prince George County, Md.

MOTHER
14. Maiden Name Mary E. Cunnick
15. Birthplace Prince George County, Md.

16 (a) Informant Mrs. N. Stumbler
(b) Address Jessup, Maryland, R.F.D.

17 (a) Burial (b) Date thereof Jan. 30, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

19 (a) JAN 29 1948 (b) Huntington Williams, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/27 19 48 at 12 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/24 19 48 to 1/27 19 48, and that I last saw h[illegible] alive on 1/27 19 48.

Immediate cause of death	Duration
Respiratory failure	
Due to Bilateral pneumonia	
Due to	
Other Conditions Arteriosclerotic c-v disease & uremia.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Bilateral pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sidney J. Vernacle, M.D.
M. D.
Address St. Agnes Hospital Date signed 1-28-48

VS 130

G59587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59587

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Howard
(a) State Md (b) County Anne Arundel
(c) City or town Elkridge (If outside city or town limits, write RURAL and give town)
(d) Street No. Railroad ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Daisy Delores German

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Thomas S. German
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) April 4 1899

8. AGE: Years	Months	Days	If less than one day
48	9	28	hr. min.

9. Birthplace Howard County, Md. (Town, county, and state)
10. Usual Occupation House work.
11. Industry or business OWN Home.

FATHER
12. Name William L. Brown
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Caroline V. Young
15. Birthplace Howard Co. Md.

16 (a) Informant W. L. Brown
(b) Address Linthicum Heights, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof JAN 31, 1948 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director Thomas W. Pingleton
(b) Address Glen Burnie, Md.

19 (a) JAN 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/28/48 1/28 1948, at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/20 1948 to 1/28 1948, and that I last saw her alive on 1/28 1948.

Immediate cause of death	Duration
Cardiac failure - H.B.P. - Cerebral Hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Manning M. D.
Address Hazel Date signed 1/28/48

VS 150

G59588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No. G59588

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Mercy Hosp 27 10

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 911 E. Cold Spring Lane (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Marie R Leinkuhler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of husband or wife Wm. Joseph Leinkuhler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1920

8. AGE: Years	Months	Days	If less than one day
27	1		hr. min.

9. Birthplace Phila (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Wm. Weinstein

13. Birthplace Phila, Pa.

MOTHER

14. Maiden Name Christina Mullins

15. Birthplace Ireland.

16 (a) Informant Marie R. Leinkuhler

(b) Address 911 E. Cold Spring Lane

17 (a) Burial (Burial, cremation, removal) (b) Date thereof 2/2/48 (month) (day) (year)

(c) Cemetery or crematory Phila. Pa.

Location

18 (a) Funeral director John J. Mohan

(b) Address 3000 E. Balto. St.

19 (a) JAN 29 1948 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 1948, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 19 48 to Jan 28 19 48 and that I last saw her alive on Jan 28 1948.

Immediate cause of death	Duration
Ruptured Cerebral aneurism	
Due to Ruptured Pulmonary Embolism	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature W. F. Schmeckpeper M. D.

Address Mercy Date signed 1-28-48

VS 150

X

G59589

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G59589
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 19
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annabell Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Cornelius Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 8, 1897

8. AGE: Years 50 | Months 2 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Louisburg, N.C.
(Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Perry
13. Birthplace Louisburg, N.C.

MOTHER
14. Maiden Name Izora
15. Birthplace Louisburg, N.C.

16 (a) Informant Cornelius Smith
(b) Address 1415 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 1 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 922 N. Schroeder St.

19 (a) 1948 (Dated'rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27, 1948, at 7:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Rest death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Myocardial hypertrophy and degeneration
Acute pulmonary edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 1/28/48

VS 151

Typing, write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G59590 Registered No. 1312

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U S Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) --

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 204 Myrtle Ave, Balto., Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Brown, Napoleon

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW I	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	c	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 25, 1893

8. AGE: Years	Months	Days	If less than one day
54	9	2	hr. min.

9. Birthplace Ypsilanto, Mich. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name James Brown
13. Birthplace unknown

MOTHER
14. Maiden Name Angeline ?
15 Birthplace Unknown

16 (a) Informant Records
(b) Address U S Marine Hospital, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 2 1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location

18 (a) Funeral director W.S. Katie R. Williams
(b) Address 222 N. Schroeder St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27, 1948, at 10:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 21, 1948, to Jan. 27, 1948, and that I last saw him alive on Jan. 27, 1948.

Immediate cause of death Arteriolar nephrosclerosis — Duration 2 years
2-Elevation of blood pressure — 2 years
3-Cardiac insufficiency — 1 year
4-Uremia — 1 month

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address U. S. Marine Hospital Date signed 1-28-48
Baltimore 11, Md.

VS 150

G59591

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G59591 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Dot
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 17
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 514 N. Pine St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME William Bates

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Colored	married

6 (b) Name of husband or wife: Beatrice Bates
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 15, 1902

8. AGE:	Years	Months	Days	If less than one day
	44	10	13	hr. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual Occupation: Laborer
11. Industry or business

MOTHER — FATHER

12. Name: John Bates.
13. Birthplace: Virginia
14. Maiden Name: Ella Macklin.
15. Birthplace: Virginia

16 (a) Informant: Beatrice Bates.
(b) Address: 514 N. Pine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan. 31, 1948 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary
Location:

18 (a) Funeral director: Mrs. Katie R. Williams
(b) Address: 522 W. Baltimore St.

19 (a) (Date rec'd by registrar) (b) Faustina Fer Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/28 1948, at 9:15 A.M.

21. I ~~certify~~ that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Chronic Myocardial Degeneration

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: [illegible] M.D.
Medical Examiner.
Date signed: 1/28/48

PRESS WRITE FIRMLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G59592

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 321 S. Bentalou St.
(c) Hospital or institution: 70-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 321 S. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Imhof

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elsa C. Imhof

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1878

8. AGE: Years 69 | Months 2 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business Self.

FATHER
12. Name John H. Imhof
13. Birthplace Germany

MOTHER
14. Maiden Name Marie C. Bach
15. Birthplace Germany

16 (a) Informant Elsa Charlotte Imhof
(b) Address 321 S. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-30-48 (month) (day) (year)
(c) Cemetery or crematory Loudon
Location Baltimore, Md.

18 (a) Funeral director George L. Schnurr
(b) Address 2101 Frederick Ave

19 (a) JAN 30 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 1948, at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1948, to Jan 25 1948, and that I last saw h[illegible] alive on Jan 25 1948.

Immediate cause of death	Duration
Coronary Thrombosis	3 days
Due to Myocardial Infarction	3 yrs.
Due to Arteriosclerosis	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. Imhof Jr M. D.
Address 1932 Eutaw Pl Date signed 1/28/48

VS 150

G59593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. G59593

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 153 Hillard St.

(c) Hospital or institution: Not

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)

(d) Street No. 153 Hillard St. (If rural give location)

(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME August Charles Kerbe

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Minnie L. Kerbe

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) August 13, 1874

8. AGE: Years 73 | Months 5 | Days 16 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Alfred Kerbe

13. Birthplace

MOTHER 14. Maiden Name Madeline

15. Birthplace

16 (a) Informant Mrs. Minnie L. Kerbe

(b) Address 153 Hillard Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Maryland

18 (a) Funeral director George L. Ephraim

(b) Address 2101 Eastern Ave.

19 JAN 30 1948 (Date rec'd by registrar) Permit for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29, 1948, at 11:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1948 to Jan 29 1948 and that I last saw him alive on Jan 29 1948.

Immediate cause of death Pulmonary Edema

Due to Death Compensation Order Feature.

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Robert C. Kirkley M. D.

Address 2151 Eutaw Pl. Date signed Jan 30 1948

G59594 JL - 116947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

Registered No. G59594

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1149 Washington Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A Johnson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of ~~husband or~~ wife Emma Louise Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29, 1880

8. AGE: Years	Months	Days	If less than one day
67	10	0	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Laborer

FATHER
12. Name William Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Solly
15. Birthplace Md.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/3/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Sollers
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 JAN 30 1948 (Date rec'd by registrar) (b) Filed Feb 3 1948 Registrar, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29 1948, at 6.25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 27 1948, to Jan. 29 1948, and that I last saw h im alive on Jan. 29 1948.

Immediate cause of death	Duration
Bronchopneumonia.	2 Days
Due to Peritonitis due to ruptured diverticulum of sigmoid.	6 Days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1-27-48
Major findings of operation Peritonitis
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. E. Groce, M. D.
Address 4940 Eastern Ave Date signed 1-29-48

G59595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

G59595 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + 33rd Sts
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 da.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3211 St. Paul St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Mr. George A. Dreberg

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1883

8. AGE: Years	Months	Days	If less than one day
64 65	4	23	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Family Mem
11. Industry or business —

FATHER
12. Name Mr. George Dreberg
13. Birthplace Maryland

MOTHER
14. Maiden Name Alice Manley
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Joseph Hauer
(b) Address 3211 St. Paul St. City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/30/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave, Extended

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29 1948, at 12 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 31 1947 to Jan 29 1948. and that I last saw h[illegible] alive on Jan 29 1948

Immediate cause of death Carcinoma of Stomach — Duration 1

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1-2-48

Major findings of operation: Metastatic Carcinoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Union Mem. Hosp. Date signed 1-29-48

VS 150

STEIN

G59596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. G59596

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address General Hospt.

(c) Hospital or institution: 27-17

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. Turndale

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Samuel Stein

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1868

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Not Known

13. Birthplace Russia

MOTHER 14. Maiden Name Not Known

15 Birthplace Russia

16 (a) Informant Hosp Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-30-48 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel

Location Germantown Hill Rd

18 (a) Funeral director Jas. C. Lewis Inc

(b) Address 210 Eutaw Pl.

19 (a) JAN 30 1948 (Date rec'd by registrar) (b) Reading for Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/29/1948, at 9:24 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1947 to 1/29 1948

and that I last saw h/ alive on 1/29 1948

Immediate cause of death Cancer of Pancreas — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cancer of pancreas - Death probably due to

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address Lying In Hosp Date signed 1/29/48

VS 150

X

G59597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G59597 Registered No. 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 204 North Washington
(c) Hospital or institution: 6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 204 North Washington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSA UHLFELDER

3 (b) If veteran, name war

3 (c) Social Security Account No. 10

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife David

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 70 | Months 9 | Days | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Germany

MOTHER
14. Maiden Name Mayan
15. Birthplace Germany

16 (a) Informant Milton Uhlfelder
(b) Address 2516 Loyola Southway

17 (a) Burial (b) Date thereof 2-1-48
(If burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore Hebrew
Location Belair Road

18 (a) Funeral director Jack Lewis, Inc.
(b) Address 2100 Eutaw Place

19 (a) Jan 30 1948 (b) Wm. Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/29/48 19, at 8:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Ellers M.D.
Medical Examiner.
Date signed 1/29/48

VS 151

G59598 BC-48-00743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

Registered No. G59598

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 14-V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1635 Little Walsh; (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Beverly Carter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1948.

8. AGE: Years	Months	Days	If less than one day
0	0	6	hr. min.

9. Birthplace 1635 Little Walsh St; Balt. Md (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name John
13. Birthplace Md.

MOTHER
14. Maiden Name Harriet ?
15. Birthplace Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 26 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 JAN 30 1948 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21 1948, at 3:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 16 1948 to Jan. 21 1948, and that I last saw her alive on Jan 21 1948.

Immediate cause of death Respiratory failure — Duration
Due to Overwhelming toxemia
Due to Intestinal Obstruction
Other Conditions Prematurity
(Include pregnancy within 3 months of death)
Date of operation Jan. 17, 1948
Major findings of operation: Atresia - 3cm. of descending colon
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert C. Hunter, M.D. M. D.
Address University Hospital Date signed 1-22-48

VS 153

G59599

C-48-0376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G59599 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 18-1

(a) Baltimore City, Maryland

(b) Street address: Redwood & Greene Sts.

(c) Hospital or institution: University Maryland Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2 days.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 312 North Poppleton St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Premature baby girl DIRTON (Second of the twins)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-16-48

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace University Hospital (Town, county, and state)

10. Usual Occupation Prematurity

11. Industry or business

FATHER 12. Name Curtiss Dirton

13. Birthplace N. C.

MOTHER 14. Maiden Name Gertrude Allston

15. Birthplace N. C.

16 (a) Informant Mother

(b) Address 312 North Poppleton St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical School JAN 26 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) JAN 30 1948 (Date rec'd by Registrar) (b) Wallace Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-18 1948, at 7:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-16 1948 to 1-18 1948 and that I last saw her alive on 1-18 1948

Immediate cause of death Respiratory failure

a Fetal atelectasis

Due to b Prematurity

Due to

Other Conditions Twin pregnancy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm. G. Lowry, Jr.

Address University Md. Hosp. Date signed 1-18-48 M. D.

VS 150

659600

BALTIMORE CITY HEALTH DEPARTMENT

BC-48-01738 CERTIFICATE OF DEATH 159

Registered No. 659600

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2821 Bookert Drive
(c) Hospital or institution: Home.

(d) Length of stay in hospital or inst. (yrs., mos., or days) Home 30 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore or Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2821 Bookert Dr.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Newborn (Premature) Baby Thomas.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-23-48

8. AGE: Years	Months	Days	If less than one day
—	—	—	— hr. 30 min.

9. Birthplace Baltimore, Maryland. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Thomas.
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Elizabeth Thomas.
15. Birthplace Baltimore, md.

16 (a) Informant Elizabeth Thomas.
(b) Address 2821 Bookert Drive.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 26 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 30 1948 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-23 1948 at 11:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11:05 Am 1-23, 1948 to 11:05 Am 1-23, 1948 and that I last saw him alive on 1-23 1948.

Immediate cause of death Atelectasis — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Mary M. Luck M. D.
Address 3013 Brighton Date signed 1-23-48

VS 150

59601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G59601

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 449 E. 25th St.
(c) Hospital or institution: 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 449 E. 25th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA R. POTTERFIELD

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Frank B. Potterfield
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 22. 1878

8. AGE: Years 69 | Months 11 | Days 6 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Hardesty
13. Birthplace Baltimore

MOTHER
14. Maiden Name Laura Hardwood
15. Birthplace Maryland

16 (a) Informant Mr. Walter C. Potterfield
(b) Address 449 E. 25th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 30. 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address Baltimore 13 Md.

19 (a) JAN 30 1948 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28, 1948 at 4.00A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1st 1947 to Jan 28 1948 and that I last saw her alive on Jan 28 1948.

Immediate cause of death: Carcinoma of Breast — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation about Nov.

Major findings of operation: Carcinoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Ehrlich M. D.
Address 443 E 25th Date signed 1-28-48

X

VS 150

C59603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. C59603

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2011 Madison Ave.
(c) Hospital or institution: 14.3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2011 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah A. Dorsey

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1862

8. AGE: Years	Months	Days	If less than one day
86	-	15	hr. min.

9. Birthplace Catonsville, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Dorsey
13. Birthplace Md.

MOTHER
14. Maiden Name Julia Dorsey
15. Birthplace Md.

16 (a) Informant Mrs. Ariel D. Baker
(b) Address 2011 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-31-48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 528 W. Biddle Street

19 JAN 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V S 130

MEDICAL CERTIFICATION P

20. DATE OF DEATH January 28, 1948 at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24 1948 to Jan 28 1948 and that I last saw h[illegible] alive on Jan 28 1948

Immediate cause of death Bronchopneumonia — Duration: 1 week 7 days

Due to

Due to

Other conditions Senility

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S. B. Hughes M.D.
Address 1413 Hull St Date Jan 29-48

G59603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

168

G59603 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22-1
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 Welcome Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID GIBBS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 40 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state) Unknown

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School JAN 27 1948 Commissioner of Health

18 (a) Funeral director

(b) Address

19 (a) JAN 30 1948 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19, 1948, at 12.30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull
Intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 1-18-48 12 P. M.
(b) Where did injury occur? outside- 107 Welcome Alley Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Hit on head with brick

23. Signature Carl L. Boyer M.D. Medical Examiner.

Date signed 1-19-48

VS 151

C59604

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. C59604

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 21-1
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 531 W. Cross St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nathan Hemingway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 50 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 27 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 30 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Jan. 1948, at 1:30 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Exposure to Cold

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D. Medical Examiner.
Date signed 19 Jan. 1948

G59605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

Registered No. G59605

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6-5
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 E. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James E. Green

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace (Town, county, and state) Louisiana
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Unknown
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 27 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) JAN 30 1948 (Date rec'd by registrar) (b) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Jan. 1948, at 11:50 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to Probable syphilitic heart disease

Other Conditions Penile & scrotal ulceration.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D. Medical Examiner.
Date signed 19 Jan. 1948

VS 19t

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 106 B

G59606
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. A. Co
(c) City or town Arnold
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Becker

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Wh | 6 (a) Single, married, widowed, or divorced. ~~Married~~ Single Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 21 1873

8. AGE: Years 74 | Months 3 | Days 7 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county and state)

10. Usual Occupation Funeral Director

11. Industry or business Retired

FATHER
12. Name Louis Becker
13. Birthplace Germany

MOTHER
14. Maiden Name Theresa Puls
15. Birthplace Germany

16 (a) Informant John J. Dressler
(b) Address Calvert & Fayette

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 31 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address McCulloh & Orchard Sts

19 JAN 30 1948 (Date rec'd by registrar) (b) Signature of Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 1948, at 12 50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1948 to Jan 28 1948, and that I last saw him alive on Jan 24 1948.

Immediate cause of death Pneumonia, Influenza — Duration

Due to

Due to

Other Conditions Chronic Cardiac Chronic bronchitis
(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Union Hosp (Date signed 1/30/48)

VS 150

G59607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1210

Registered No. G59607

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 years

2. USUAL RESIDENCE OF DECEASED
(a) State Md (b) County Baltimore
(c) City or town Baltimore Overmeade (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 Bayside Drive Randolph (If rural give location)
(e) Citizen of foreign country? Not (Yes or No)
If yes, name country

3 (a) FULL NAME George W Harris

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 212-05-4063

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dorothy Harris
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) June 15, 1908

8. AGE: Years 39 | Months 7 | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace Reedville, Virginia (Town, county, and state)

10. Usual Occupation Power operator

11. Industry or business Consolidated Gas & Elect. Co.

FATHER
12. Name George Harris
13. Birthplace Virginia

MOTHER
14. Maiden Name Georgette Olivia
15. Birthplace Virginia

16 (a) Informant wife
(b) Address 519 Bayside Dr.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/48 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Parkwood
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves; Balto., Md.

19 (a) JAN 30 1948 (Date rec'd by registrar) (b) Trustin for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1948, at 3:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1948 to Jan 29 1948, and that I last saw him alive on Jan 29 1948.

Immediate cause of death: Chronic glomerular nephritis — Duration: 2 years
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Miller M. D.
Address South Balto Gen Date signed 1/29/48

VS 150

G59608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G59608

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3301 Richmond Ave.
(c) Hospital or institution: 8-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 3301 Richmond Ave.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore, Md.
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME ANNA BARBARA HOWARD

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Charles D.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jun. 25, 1886

8. AGE: Years	Months	Days	If less than one day
61	7	3	hr. min.

9. Birthplace Washington, D.C.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business --

FATHER
12. Name Joseph E. Peissner
13. Birthplace Germany

MOTHER
14. Maiden Name Agusta Scharfe
15. Birthplace Germany

16 (a) Informant John T. Howard
(b) Address 3301 Richmond Ave.

17 (a) Burial (b) Date thereof 1/31/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore, Md.
Location Baltimore

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Ave; Balto., Md.

JAN 30 1948 (b) Theodore Von Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-25-1943 to 1-28-1948 and that I last saw her alive on 1-27-1948

Immediate cause of death	Duration
Coronary Thrombosis	6 hours
Due to Cardio-vascular renal Disease	1943
Due to Generalised arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Shelton C. Craig M. D.
Address 2117 Belair Rd Date signed 1-29-48

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G59609 Registered No. 13B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 727 Saratoga St
(c) Hospital or institution: 4 2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) All Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 727 W. Saratoga St
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) **FULL NAME** Eugenia Bell Robinson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Frank Robinson
6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) 1928

8. AGE: Years 20 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Eugen Bell
13. Birthplace Maryland

MOTHER
14. Maiden Name Eugenia Fauner
15. Birthplace Baltimore, Md

16 (a) Informant Frank Robinson
(b) Address 727 W. Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 31-1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Baltimore Md

18 (a) Funeral director Elroy B. Wilson
(b) Address 1010 Betterly Ave

19 (a) JAN 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M. D. Registrar

MEDICAL CERTIFICATION Jan 28 2:45 am

20. DATE OF DEATH Jan 28 1948, at 2:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1947 to Jan 1948, and that I last saw h.. alive on Jan 28 1948.

Immediate cause of death	Duration
Lobar Pneumonia	7 days
Due to	
Due to	
Other Conditions Pul Tbc.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Garland Shirell Jr. M. D.
Address 902 W. Franklin Date signed 1-28-48

VS 150

108

C59610
AB-114071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C59610

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 3-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7 South Central Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laura Cager

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6- 1912

8. AGE: Years	Months	Days	If less than one day
35	3	19	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Arthur Jones
13. Birthplace Virginia

MOTHER
14. Maiden Name Mattie Downey (D
15. Birthplace Virginia

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy Allstadt
(b) Address 1000 Brentley Ave

19 (a) JAN 30 1948 (Date rec'd by registrar) (b) Clayton Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25 1948, at 10.20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-25- 1947 to 1-25- 1948, and that I last saw her alive on 1-25- 1948

Immediate cause of death Bilateral tuberculosis, far advanced pulmonary — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H Neikam Jr M.D.
Address Balto City Hosp Date signed 2-2-48

1214 E. Ed St

G59611

GM. 115844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1363

Registered No. G59611

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 8-7

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month

(e) Length of stay in Baltimore (yrs., mos., or days) 6 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1225 N. Caroline ST. Z 13 (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ruby Lee Watson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Seperated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July -14 - 1919

8. AGE: Years	Months	Days	If less than one day
28	6	13	hr. min.

9. Birthplace GA. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Ekiah Timmons

13. Birthplace S.C.

MOTHER

14. Maiden Name Etta Williams

15. Birthplace GA.

16 (a) Informant Records Baltimore Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 31-1948 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem.

Location Brooklyn, Md

18 (a) Funeral director Chas O. Wilson

(b) Address 1000 Bentley ave

19 (a) JAN 30 1948 (Date rec'd by registrar) (b) Registrar Williams

Def 20M

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27 - 1948, at 3.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-12- 1947 to Jan. 27 1948. and that I last saw her alive on Jan. 27 - 1948

Immediate cause of death Pulmonary Tuberculosis — Duration 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature D C Robinson M.D.

Address Balt City Hosp Date signed 1-28-48

G59612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218

Registered No. G59612

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: E-1
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 E Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Williford James.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Macrethan
6 (c) If alive, give age 15 years

7. Birth date of deceased (mo., day, yr.) 3-20-28

8. AGE: Years	Months	Days	If less than one day
19	10	7	hr. min.

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Simon James.
13. Birthplace S. C.

MOTHER
14. Maiden Name Mittie Williford
15. Birthplace S. C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy Wilson
(b) Address 1000 Belvedere Ave

19 (a) JAN 30 1948 (Date rec'd by registrar) (b) Huntington Ave Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1948, at 1145 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 18 1947 to Jan 27 1948 and that I last saw him alive on Jan 27 1948.

	Duration
Immediate cause of death UREMIA	72 hrs
Due to CHRONIC Glomerulo Nephritis	
Due to	
Other Conditions CYSTITIS, PYELITIS, Etiology not determined (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy: same as above	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Isby Blaylock M. D.
Address Johns Hopkins Hospital Date signed 1/28/48

VS 150

C59613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C59613

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 19-1
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 422 N. Stricker Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME OLIVIA WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	married

6 (b) Name of husband or wife Robert E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Bridgeport, Conn. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Robert E. Williams
(b) Address 422 N. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 30, 1948 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) JAN 30 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1948, at 11:05 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congestive Heart Failure

Due to Myocardial Degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earle K. Royer M.D. Medical Examiner.
Date signed 1-28-48

VS 181

G59614

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1948

Registered No. G59614

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 18-3
(b) Street address 110 N Calhoun St.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1221 W. Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Joseph Schwartz

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Alice F.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 28, 1887
8. AGE: Years 60 | Months 5 | Days 0 | If less than one day hr. min.
9. Birthplace Lynchburg Va. (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Franklin Square Hosp.

FATHER
12. Name Joseph Schwartz
13. Birthplace [illegible]

MOTHER
14. Maiden Name Emma Adams
15. Birthplace Lynchburg Va

16 (a) Informant Mrs Alice F. Schwartz
(b) Address 1221 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/48 (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location 3801 Frederick Ave

18 (a) Funeral director John J. Gowan & Son
(b) Address 901-03 Hollins St.

19 (c) JAN 30 1948 (Date rec'd by Registrar) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Jan. 1948, at 10:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D. Medical Examiner.
Date signed 29 Jan. 48

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V131a

G59615 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2866 Kentucky Ave
(c) Hospital or institution: 27-A
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2866 Kentucky ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Friedrich Steinmetz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	

6 (b) Name of husband or wife Annie Steinmetz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 31-1859

8. AGE: Years	Months	Days	If less than one day
89	1	28	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Wolfgang Steinmetz
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Mrs Anthony Diegelman
(b) Address 2866 Kentucky Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 31-48 (month) (day) (year)
(c) Cemetery or crematory Bath
Location Balto Md

18 (a) Funeral director J. J. Herbert Son
(b) Address 3061 Kentucky Ave

19 (d) JAN 30 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/29 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1, 1947 to Jan 29 1948, and that I last saw h/M alive on Jan 29 1948.

Immediate cause of death	Duration
Arteriosclerotic Cardiovascular Renal Disease	1
Due to	
Due to	
Other Conditions Hemiplegia	4 mo.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph L. Blum M.D.
Address 206 E. Preston St Date signed 1/29/48

VS 150

659616 C 16779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 157a

Registered No. 659616

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 7-5
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1716 E. Madison St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Hamber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-25-46

8. AGE: Years 1 | Months 3 | Days 2 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Ernest Hamber

13. Birthplace Wyo.

MOTHER 14. Maiden Name Virginia Woingust

15. Birthplace Md

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-30-48 (month) (day) (year)

(c) Cemetery or crematory W. Va. Delaware

Location R. R. Co

18 (a) Funeral director Paynter Sanders

(b) Address 1412 E. Preston St

19 (a) JAN 30 1948 (Date rec'd by registrar) (b) Interment for Williamsport Md. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1948, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1948 to Jan 27 1948 and that I last saw h[illegible] alive on Jan 26 1948.

Immediate cause of death: cardio-respiratory failure — Duration

Due to: Anencephalus and Hydrocephalus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Julian Chisolm

Address Johns Hopkins Hosp. Date signed 1-27-48 M. D.

VS 150

J. Julian Chisolm-de X

C59617

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. C59617

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 167
(b) Street address
(c) Hospital or institution: Providents Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 822 Woodyear St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Brown

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Dorothy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/22/1911

8. AGE: Years 36 | Months 6 | Days — | If less than one day hr. min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Geo. Brown
13. Birthplace md

MOTHER
14. Maiden Name Nellie —
15. Birthplace md

16 (a) Informant Dorothy Brown
(b) Address 2720 Edelman Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pleasantman St

19 (a) JAN 30 1948 (Date rec'd by registrar) (b) Clayton Williams (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1948 at 8 40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of chest
Due to hemothorax

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-28-48 at 8:15 P. M.
(b) Where did injury occur? 818 Woodyear St. (front steps)
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Sharp Instrument

23. Signature Frank L Rogers M.D. (Medical Examiner)
Date signed 1/28/48

X

Please write plainly, with pen and ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59618

XB-116840 CR: 48-01547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 30F

Registered No. G59618

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2hr-40Min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 213 West Hoffman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1948

8. AGE: Years | Months | Days | If less than one day 21? hr. 40? min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Glascoe
13. Birthplace ?

MOTHER
14. Maiden Name Ethel Williams
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 1-28-48 9am (month) (day) (year)
(c) Cemetery or crematory B. C. H. Crematory
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) Jan 30 1948 (Date received by registrar) (Signature for Williams) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24 19 48, at 5.40A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-24 19 48 to 1-24 19 48, and that I last saw h im alive on 1-24 19 48.

Immediate cause of death: Premeturity — Duration: 2 hrs

Due to: — Duration: in utero

Due to: Congenital Syphilis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Syphilis, Premeturity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fabian P. Buffin M. D.
Address Balt. City Hospitals Date signed 29 Jan 48

G59619

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

Registered No. G59619

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1032 Sterling St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Crawley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	M

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
42			hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name James Seggres
13. Birthplace Md

MOTHER
14. Maiden Name Ella Lewis
15. Birthplace Md.

16 (a) Informant James Seggres
(b) Address 1032 Sterling St

17 (a) Burial (b) Date thereof 1/30/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy A Wilson
(b) Address 1000 Druid Lane

19 (a) JAN 30 1948 for William H. Hamilton M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27, 1948, at 5 a. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions Hypertension C.V.D. Renal Disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1945 at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian-struck by auto

23. Signature Earl L Royer M.D.
Medical Examiner
Date signed 1-28-48

VS 151

REGULAR WRITING, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G59620 Registered No. 833a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3036 Annah Ave
(c) Hospital or institution: 16-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3036 Annah Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Albert Horning

3 (b) If veteran, name war

3 (c) Social Security Account No. 577-07-5314

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W	MARRIED

6 (b) Name of husband or wife SELMA.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV-21-1877

8. AGE: Years	Months	Days	If less than one day
70	2	7.	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Piano Technician
11. Industry or business Self

FATHER
12. Name Julius W. Horning
13. Birthplace Germany

MOTHER
14. Maiden Name Fredrika Gelatenberg
15. Birthplace Germany

16 (a) Informant Mr Carl Horning
(b) Address 3036 Annah Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-31-48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Dickeyville

18 (a) Funeral director Geo. H. Kempfski
(b) Address 1-26 N. Lyndhurst St.

19 (a) JAN 30 1948 (Date received by Registrar) Huntington Williams, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 28 1948 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-2 19 47 to 1-28 19 48 and that I last saw h[illegible] alive on 1-28 19 48.

Immediate cause of death: Cerebral hemorrhage — Duration: 24 hours
Due to: arteriosclerosis & hypertension.
Due to: —
Other Conditions: —
(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: —
(b) Date of occurrence: — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury:

23. Signature H. W. Scheye M. D.
Address H. W. SCHEYE, M. D. Date signed
3921 EDMONDSON AVE.
BALTIMORE-29, MD.

VS 150

G59621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G59621

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1431 E. Clement St.

(c) Hospital or institution: 24-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1431 E. Clement St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THRESA MARTIN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife ANDREW MARTIN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-13-1879

8. AGE: Years	Months	Days	If less than one day
68	5	14	hr. min.

9. Birthplace HUNGARY
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER

12. Name Nicholas Schneider

13. Birthplace Hungary

MOTHER

14. Maiden Name Anna Schneider

15. Birthplace Hungary

16 (a) Informant Anna Simon

(b) Address 1431 E. Clement ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-31-48 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location A.A. Co.

18 (a) Funeral director Charles F. Muth

(b) Address 1501 E. Fort Ave

19 (a) 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27, 1948, at 11:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/20/1945 to Jan. 27, 1948. and that I last saw her alive on Jan. 15, 48.

Immediate cause of death	Duration
Acute cardiac failure	
due to coronary occlusion	1/2 hr.
Due to	
Due to	
Other Conditions Hypertensive cardio vascular disease.	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Harry Deibel M. D.

Address 1226 Hanover St. Date signed Jan. 30, 1948

VS 150

X

G59622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G59622

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calhoun & Fayette Sts 1943

(c) Hospital or institution: Franklin Sq. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hr.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County —

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1433 W Lombard St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME John H. Grace

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	married

6 (b) Name of husband or wife Madeline Grace

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27 1888

8. AGE: Years	Months	Days	If less than one day
59	7	2	hr. min.

9. Birthplace Richmond Va

(Town, county, and state)

10. Usual Occupation Cement Finisher

11. Industry or business Rukert Bull Const. Co.

FATHER 12. Name Thomas Grace

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Ella Shea

15. Birthplace Richmond, Va.

16 (a) Informant [illegible]

(b) Address [illegible]

17 (a) Removal (b) Date thereof 1-30-48

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Richmond Va

18 (a) Funeral director Geo L Berger Jr

(b) Address 1512 Hollins St

19 (a) JAN 30 1948 Huntington Williams, M.D.

(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Jan 1948, at 4-10 p M

21. I certify that death occurred on the date above stated; that I attended deceased from 29 Jan 1948 to 29 Jan 1948, and that I last saw h alive on 29 Jan 1948.

Immediate cause of death Cerebral hemorrhage

Due to Hypertensive C V Dis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature G. J. Lahan M. D.

Address Franklin Sq Hosp Date signed 31 Jan 48

659623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

659623 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6206 Pinehurst Road
(c) Hospital or institution: 27-12

(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 52 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6206 Pinehurst Road (If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME Gertrude Marie O'Neill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife George D. O'Neill
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Mar. 26, 1895

8. AGE: Years	Months	Days	If less than one day
52	10	2	-- hr. --- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business --------

MOTHER / FATHER
12. Name Aloysius Carroll Smith
13. Birthplace Baltimore, Maryland
14. Maiden Name Ella Meek
15. Birthplace Baltimore, Maryland

16 (a) Informant George D. O'Neill
(b) Address 6206 Pinehurst Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director No. D. Mears and Son
(b) Address 805 N. Calvert Street

19 JAN 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28 1948, at 12 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1947 to Jan 28 1948, and that I last saw h[illegible] alive on Jan 28 1948.

Immediate cause of death	Duration
Carcinomatosis	2 mo
Due to Carcinoma of breast	6 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J Edwin Mulley M.D.
Address 24 Read St Date signed Jan 29 '48

VS 150

X

G59624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G59624

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St — 10-1
(c) Hospital or institution: Home For The Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Docia Rice

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	W.

6 (b) Name of husband or wife Jack Rice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1869

8. AGE: Years	Months	Days	If less than one day
78	3 2	12	hr. min.

9. Birthplace St Mary's Co. Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Frank Farrer
13. Birthplace

MOTHER
14. Maiden Name Martha Herbert
15. Birthplace

16 (a) Informant Ella Lindsey For the Poor
(b) Address 1200 Valley St

17 (a) (Burial, cremation, or removal) (b) Date thereof Feb 2 -48 (month) (day) (year)
(c) Cemetery or crematory St Mary's Cem
Location Bel Alton Md

18 (a) Funeral director Hunt & Ryan
(b) Address Waldorf, Md

19 (a) JAN 30 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27 1948, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1948 to Jan 29 1948 and that I last saw her alive on Jan 25 1948.

Immediate cause of death	Duration
Diabetes Mellitus	5 yrs
Due to	
Due to	
Other Conditions Gangrene Toe Lt.	1 month

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E North Ave. Date signed

VS 150

659625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59625

1108 Wilkens

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1712 N. Calhoun Street
(c) Hospital or institution: 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 N. Calhoun Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ESTER ROBERT BRYSON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife Florence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25, 1910

8. AGE: Years	Months	Days	If less than one day
37	7	2	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Chef Cook
11. Industry or business

MOTHER | FATHER
12. Name Kenny Bryson
13. Birthplace Virginia

MOTHER
14. Maiden Name ??? Jones
15. Birthplace Virginia

16 (a) Informant Mrs. Florence Bryson
(b) Address 1712 N. Calhoun Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 31, 1948 (month) (day) (year)
(c) Cemetery or crematory Rocky Hill
Location Montgomery Co. Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) JAN 30 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH 1/27 1948, at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/11 1948 to 1/27 1948, and that I last saw him alive on 1/22 1948.

Immediate cause of death	Duration
Lobar Pneumonia (Right)	
Due to	16 days
Due to	
Other Conditions Malnutrition	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Preston Hearn M. D.
Address 1514 Division Date signed 1/28/48

VS 150

659626 8921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

659626 Registered No. 1328

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 14-3
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) life
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2131 Division St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hugh Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-24-29

8. AGE: Years	Months	Days	If less than one day
18	8	4	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

MOTHER / FATHER
12. Name Austin Williams
13. Birthplace Md.
14. Maiden Name Rosa Wiggins
15. Birthplace Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 1 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore, Co. Md.

18 (a) Funeral director Wm. George & H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) Date received by Registrar Jan 30 1948 (b) Registrar Austin Williams, M.D.

VS 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Jan. 28 1948 at 4.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19 1948 to Jan. 28 1948 and that I last saw him alive on Jan. 28 1948

Immediate cause of death	Duration
Pulmonary embolism	½ hr
Due to	
Due to	
Other Conditions Pulmonary TB c 3 yrs with cavities and hemoptysis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Victor A. McKusick M. D.
Address Johns Hopkins Hosp. Date signed 1/28/48

111a

C59627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C59627

46 12

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 523 S. Ann Street
(c) Hospital or institution: 2-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 523 S. Ann Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME James Victor Krzystynski

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-09-6421

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Agnes Krzystynski
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation B. O. R. R. Co.

11. Industry or business

FATHER
12. Name Jacub Krzystynski
13. Birthplace Poland

MOTHER
14. Maiden Name Helen Koryto
15. Birthplace Poland

16 (a) Informant Mrs. Agnes Krzystynski
(b) Address 523 S. Ann Street

17 (a) ~~Not~~ Burial (Burial, cremation, or removal) (b) Date thereof 2 - 2 - 48 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street Huntingtown Williams, Md.

19 (a) Filed 2-2-1948 (b) Registrar

MEDICAL CERTIFICATION 10.10

20. DATE OF DEATH 29th Jan. 1948, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 8 1948 to Jan. 29 1948 and that I last saw him alive on Jan. 29 1948.

Immediate cause of death	Duration
Congestive Heart Failure.	12 hrs.
Due to Generalized Carcinomatosis	
Due to Ca. Stomach	
" Liver (metastatic)	
Other Conditions Jaundice Cachexia	

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Dropp M. D.
Address 2601 Eastern Ave Date signed 1/29/48

VS 150

G59628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 27

Registered No. G59628

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3900 N Hilton Road Apt158

(c) Hospital or institution: (S-11)

(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 yrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3900 N Hilton Road Apt 158 (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Elizabeth Samler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow ~~Late Isidore~~

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years	Months	Days	If less than one day
77 76			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Joseph Franklin

13. Birthplace Russia

MOTHER 14. Maiden Name Mollie Baylis

15. Birthplace Russia

16 (a) Informant Arthur Samler

(b) Address 601 Whitelock St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 1, 1948 (month) (day) (year)

(c) Cemetery or crematory Baltimore Hebrew Cem

Location Belair Road

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124-1126 W North Ave

19 (a) JAN 30 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1948, at 8.40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1941 to JAN. 29 1948; and that I last saw her alive on Jan. 29 1948.

Immediate cause of death	Duration
Coronary Occlusion	½ hr.
Due to Coronary Sclerosis	1 yr.
Due to Arteriosclerotic - Hypertensive C-V Dis.	15 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Herbert Goldstone M. D.

Address 7443 Linden Av Date signed Jan. 30.

C59629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C59629

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland 27-4

(b) Street address Redwood & Greene Sts.

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4

(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto City

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5929 Bertram ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Coon, Rose M.

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-7217

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Married

6 (b) Name of husband or wife Aledo B

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 20-1903

8. AGE: Years	Months	Days	If less than one day
44	1	8	hr. min.

9. Birthplace Balto Co

(Town, county and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER

12. Name Franklin B Sill

13. Birthplace Pa

MOTHER

14. Maiden Name Mary E Cooper

15. Birthplace Balto Co

16 (a) Informant Aledo B Coon

(b) Address 5929 Bertram Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-31-48 (month) (day) (year)

(c) Cemetery or crematory Mt Zion

Location Balto Co.

18 (a) Funeral director Frank H Seitz

(b) Address 814 N 36 St

19 (a) JAN 30 1948 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 1948, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1948 to Jan 28 1948, and that I last saw h[illegible] alive on Jan 28 1948.

Immediate cause of death	Duration
(a) Pulmonary edema,	
Due to (b) Mitral Stenosis	
Due to	
Other Conditions Auricular fibrillation	
Lobar pneumonia, rt.	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Same as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Everyone Jr M. D.

Address Lenox Hosp Date signed 1/29/48

VS 159

92B

059630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1312

Registered No. 059630

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 628 W Lanvale St
(c) Hospital or institution: 17-V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 628 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fielder Brown.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: separated

6 (b) Name of husband or wife: Clara Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1884

8. AGE: Years 63 | Months 5 | Days 1 | If less than one day: hr. min.

9. Birthplace Lothian, Md. (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Loyd Brown.
13. Birthplace Lothian Md.

MOTHER
14. Maiden Name Harriett Owens.
15. Birthplace Lothian Md.

16 (a) Informant Mongella Howard.
(b) Address 1026 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 1 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Zion Cemetery
Location Lothian Md.

18 (a) Funeral director Mrs Fritz R. Williams
(b) Address 322 N Schroeder St.

19 JAN 30 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28 1948 at 12:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 24 1948 to Jan. 28 1948, and that I last saw him alive on Jan. 27 1948

Immediate cause of death	Duration
Nephritis Uremia	2 weeks
Due to Arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George McDonald M. D.
Address 844 N Carey Date signed 1/30/48

X

G59631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59631

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 204 Myrtle Ave
(c) Hospital or institution: 4-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 204 Myrtle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. White.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1890

8. AGE: Years	Months	Days	If less than one day
57	3		hr. min.

9. Birthplace Norfolk, Virginia
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace —

MOTHER
14. Maiden Name Unknown
15. Birthplace —

16 (a) Informant Marcilla Miller
(b) Address 204 Myrtle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 2 1948 (month) (day) (year)

(c) Cemetery or crematory Balto. National Cem.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

JAN 30 1948

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1948, at 12:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1948 to Jan 27 1948
and that I last saw ... alive on Jan 27 1948.

Immediate cause of death Cerebral hemorrhage — Duration 1 day

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 25 W. Preston Date signed 1/30/48

VS 150

59632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 59632

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Medical Division
(b) Street address — Mt. Claire Shops- Balto.Md.
(c) Hospital or institution: 16-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State — Md. (b) County
(c) City or town — Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. — 4002 Woodridge Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME — FREDERICK KASEMEYER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife — Margaret Kasemeyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1889

8. AGE: Years 58 Yr. 2. | Months 6 | Days 16 | If less than one day ... hr. ... min.

9. Birthplace — Balto. Md.
(Town, county, and state)

10. Usual Occupation — Machinist

11. Industry or business — B. & O. R. R.

FATHER
12. Name — Louise Kasemeyer
13. Birthplace — Md.

MOTHER
14. Maiden Name — Anna Stang
15. Birthplace — Md.

16 (a) Informant — Mrs. Margaret Kasemeyer
(b) Address — 4002 Woodridge Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 31/48. (month) (day) (year)
(c) Cemetery or crematory — Loudon Park
Location — 3801 Frederick Rd.

18 (a) Funeral director — Harry A. Nitzke
(b) Address — 4101 Edmondson Ave.

19 (a) JAN 30 1948 (Date rec'd by registrar) — Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27, 1948, at 2.50 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH — Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature — Earle Krayer M.D.
Medical Examiner.

Date signed 1-28-48

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 559633

559633 JL - 82586 1937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 Wolfe St. (904 N. Eden St)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary L. Smith

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife William (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 4, 1871

8. AGE: Years 76 | Months 10 | Days 24 | If less than one day hr. min.

9. Birthplace Delaware
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Albert Thompson
13. Birthplace Va.

MOTHER
14. Maiden Name Rachal ?
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/48 (month) (day) (year)
(c) Cemetery or crematory Westview Memorial Park
Location
18 (a) Funeral director Robert L. Young
(b) Address 1216 W. Caroline St
19 (a) (Date rec'd by local registrar) JAN 30 1948 (b) Huntington Williams Registrar

US 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28 1948, at 7.15 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan. 28 1948 to July 13 1948, and that I last saw her alive on Jan. 28 1948

	Duration
Immediate cause of death: Cardiac Failure	
Due to: Anteroseptal Heart Disease	6 yrs
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. C. Robinson Jr. M. D.
Address Balt. City, Md. Date signed 1/29/48

C59634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

C59634 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 720 W. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLAUDE WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 67 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant unknown
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JAN 27 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8, 1948, at 12.55 P M

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Myocardial hypertrophy, dilatation, and degeneration
Due to Edema of lungs
Anasarca

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 1-9-48

VS 151

G59635

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G59635 Registered No. 1579

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days) lt

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town White Marsh (If outside city or town limits, write RURAL and give town)
(d) Street No. Route 7 - (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Ellen Wright

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24-1947

8. AGE: Years	Months	Days	If less than one day
	6	5	hr. min.

9. Birthplace Balto Co (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jackson H. Wright
13. Birthplace Md.

MOTHER
14. Maiden Name Massey Lucas
15. Birthplace Florida

16 (a) Informant Jackson H. Wright
(b) Address White Marsh

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-48 (month) (day) (year)
(c) Cemetery or crematory Westley
Location Cecil County

18 (a) Funeral director J. Bruce Gittings
(b) Address 1466 Eastern Ave Rd

19 (a) Filed (b) rec'd by registrar Jan 30 1948 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1948 at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/4 1947 to 1/29 1948
and that I last saw her alive on 1/29 1948

Immediate cause of death	Duration
general debility	
Due to Pyelonephritis	
Due to Congenital atresia of Sigmoid colon	
Other Conditions none	

(Include pregnancy within 3 months of death)

Date of operation 9/4/47; 9/24/47; 1/9/48; 1/29/48
Major findings of operation: Same as above
of autopsy: not obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John T. Miller, M.D.
Address Maryland Gen. Hosp. Date signed 1/29/48
Med. & Surgical Res.

G59636

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

G59636
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1721 Linden Avenue
(c) Hospital or institution:

14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 Linden Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THELMA WALTERS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

8. AGE: Years	Months	Days	If less than one day
36 35			hr. min.

9. Birthplace
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Phillips Funeral Home
(b) Address Toronto Ohio

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/30/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Toronto, Ohio

18 (a) Funeral director William Corbett
(b) Address 217 Court St

19 (a) JAN 31 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

JAN 31 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 1948, at 3 A M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Lobar Pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Ryle M.D.
Medical Examiner.
Date signed 1-26-48

X

059637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

Registered No. U39637

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given, or "unknown" supplied. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert St

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Pikesville (If outside city or town limits, write RURAL and give town)

(d) Street No. 1708 Reisterstown Rd (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME John Henry Frieger, Jr

3 (b) If veteran, name war ?

3 (c) Social Security Account No. ?

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Alice Frieger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 14, 1903

8. AGE: Years 44 | Months 1 | Days 16 | If less than one day hr. min.

9. Birthplace Reisterstown, Md (Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business

FATHER 12. Name John H. Frieger

FATHER 13. Birthplace Md

MOTHER 14. Maiden Name Laura Faulstich

MOTHER 15. Birthplace Md

16 (a) Informant Hospital record

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 2 48 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Balto Co.

18 (a) Funeral director J. F. Ellenstein

(b) Address Reisterstown Md

19 (Date rec'd by registrar) JAN 31 1948 (Signature) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-30-48 19 , at 7:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-27 1948 to 1-30 1948.

and that I last saw him alive on 1-30 1948.

Immediate cause of death Hemorrhage from esophageal varix

Due to cirrhosis of liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration
2 mos

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature George P. Thomas M. D.

Address Union Memorial Hospital Date signed 1-30-48

VS 150

G59638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54a

Registered No. G59638

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 12 days
(e) Length of stay in Baltimore (yrs., mos., or days): 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: N. C. (b) County:
(c) City or town: Supply
(If outside city or town limits, write RURAL and give town)
(d) Street No.: Rt. 1, Box 142
(If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country:

3 (a) FULL NAME: Hewett, Charles Anthony, Sr.

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife: Ettie Hewett
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 9, 1907

8. AGE: Years	Months	Days	If less than one day
40	10	20	hr. min.

9. Birthplace: Supply, N. C. (Town, county, and state)
10. Usual Occupation: Engineer
11. Industry or business: Seafarer

FATHER
12. Name: Dempsey Hewett
13. Birthplace: North Carolina

MOTHER
14. Maiden Name: Rebecca Arnold
15 Birthplace: North Carolina

16 (a) Informant: Records
(b) Address: U. S. Marine Hospital, Balto, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory: Whiteville N. C.
Location:

18 (a) Funeral director: Wm. J. Tickner & Son's
(b) Address: North & Pensylvania Ave's

JAN 31 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 29, 1948, at 4:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 17, 1948, to Jan. 29, 1948 and that I last saw h_ imalive on Jan. 29, 1948.

Immediate cause of death: Neoplasm of brain, type undetermined, postoperative — Duration: 1 month
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: not done

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: U. S. Marine Hospital Date signed: 1-30-48
Baltimore 11, Maryland

VS 150

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully compiled. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

C59639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. C59639

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 310 S. CLINTON ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 310. S. CLINTON ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** SARAH LUCINDA HARDER.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOW

6 (b) Name of husband or wife CHARLES H. HARDER
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) JUNE 24, 1879

8. AGE: Years	Months	Days	If less than one day
68	7	4	hr. min.

9. Birthplace COLUMBIA Co. N. Y. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name JOHN H. MYERS
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name — JACKSON
15 Birthplace UNKNOWN

16 (a) Informant CHARLES H. HALL
(b) Address 310 S. CLINTON ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1 31 48 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE.

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST.

19 (a) JAN 31 1948 (b) Washington Williams Registrar
Date received by registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 1948, at 3 9. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1930 to Jan 28 1948, and that I last saw h[illegible] alive on Jan 27 1948

Immediate cause of death	Duration
Cerebral Hemorrhage Jaundice	1948
Hypertension	1930
Due to Nephritis -	1930
Ulcer of Leg	1934
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury ABRAM J. BLECKMAN

23. Signature Abram J. Bleckman M. D.
Address 3426 Bank St Date signed Jan 29 48

X

G59640 BC-48-01879 G59640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1579

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave.
(c) Hospital or institution: St. Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County U. L. A.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 N. Decker Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Kehoe
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex female
5. Color or race white
6 (a) Single, married, widowed, or divorced. single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 29, 1948
8. AGE: Years Months Days 3 If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name James C. Kehoe
13. Birthplace
MOTHER 14. Maiden Name Norma Pence
15. Birthplace Pa
16 (a) Informant James C. Kehoe
(b) Address 1505 N. Decker Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31-48 (month) (day) (year)
(c) Cemetery or crematory Bath Haven
Location Eastern Ave Balt. Md
18 (a) Funeral director Grant Della Rose
(b) Address 52 N. Morley St
19 (a) JAN 31 1948 (Date rec'd by reg'r) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1948 at 2:10 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26, 1948 to Jan 29 1948 and that I last saw h[illegible] alive on Jan 29 1948.

Immediate cause of death Peritonitis — Duration 3 days
Due to Ruptured Appetix — Congenital
Due to Atresia of Duodenum — Congenital
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Peritonitis, Ruptured Appendix, Atresia of Duodenum

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature L. W. Sherwin M. D.
Address St Agnes Hosp Baltimore, Md. Date signed 1-30-48

VS 150

C59641 HILL

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C59641 52a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Mercy Hospital

(c) Hospital or institution Calvert St.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County A A

(c) City or town Brooklyn Md R. F. D. (If outside city or town limits, write RURAL and give town)

(d) Street No. Furnace Branch Rd. (If in institution, give former residence)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Roland S. Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mrs. Rosalie Hill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 10, 1886

8. AGE: Years	Months	Days	If less than one day
62	0	10	hr. min.

9. Birthplace Virginia (Town, county, and State)

10. Usual Occupation Night Club owner

11. Industry or business

FATHER 12. Name ? Unknown

13. Birthplace Virginia

MOTHER 14. Maiden Name ? Unknown

15. Birthplace Virginia

16 (a) Informant Wife

(b) Address Furnace Branch Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb (month) 4 (day) 48 (year)

(c) Cemetery or crematory Western

Location Balto Md

18 (a) Funeral director Thomas W. Singleton

(b) Address Glen Burnie, Md

JAN 31 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1948 at 7:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14 1948 to Jan 30 1948, and that I last saw him alive on Jan 30 1948.

Immediate cause of death Respiratory failure

Due to Cachexia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature L M Jenzon M. D.

Address Mercy Hosp. Date signed Jan 30.

G59642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G59642

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 210 E. Chase St.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 E. Chase St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Addie Lee Elliott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Arthur J. Elliott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 25, 1866

8. AGE: Years	Months	Days	If less than one day
81	3	5	hr. min.

9. Birthplace Queen Anne County, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name ? Covington
13. Birthplace Md.

MOTHER
14. Maiden Name Hester Strong
15. Birthplace Md.

16 (a) Informant Arthur J. Elliott
(b) Address 210 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/48 (month) (day) (year)
(c) Cemetery ~~Cremation~~ Chesterfield
Location Centerville, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) JAN 31 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 1948, at 1:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 30 July 1941, to 30 Jan. 1948, and that I last saw her alive on 29 Jan. 1948.

Immediate cause of death	Duration
Heart failure	3 days
Due to Arteriosclerotic heart disease	?
Due to	
Other Conditions Coronary thrombosis (4 Aug. 1947)	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Douglas Lockard M. D.
Address 802 Cathedral St. Date signed

VS 150

Dr. D. Lockard

C59643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

C59643 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3714 Chesholm Road
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3714 Chesholm Road
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Spencer

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Blanch Shepard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1890

8. AGE: Years	Months	Days	If less than one day
57	1	16	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Landscape Engineer
11. Industry or business

FATHER
12. Name Willis Spencer
13. Birthplace Va.

MOTHER
14. Maiden Name Lucy Morgan
15. Birthplace Va.

16 (a) Informant Mrs. Blanch S. Spencer
(b) Address 3714 Chesholm Road

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 1/31/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave., Balto.

18 (a) Funeral director John O. Mitchell & Son, Inc.
(b) Address 1900 Eutaw Place

19 (a) JAN 31 1948 (Date rec'd by registrar) (b) Huntington Wills Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1948, at 90 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 19 47 to Jan 29 19 48.
and that I last saw h. alive on Jan 29 19 48.

Immediate cause of death Terminal

Due to Carcinoma - primary cervical gland

Due to mk ketastases

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Bendel M. D.
Address 2314 W. North Ave. Date signed 1/30/48

VS 150

Dr. Nathan Mettle

G59644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

Registered No. G59644

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 217 N. Chester St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 217 N. Chester St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Testudine

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Salvatore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7 1865

8. AGE: Years 82 | Months 5 | Days 22 | If less than one day hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Charles Busterna
13. Birthplace Italy

MOTHER
14. Maiden Name Mary ?
15. Birthplace Italy

16 (a) Informant Charles Testudine
(b) Address 217 N. Chester St.

17 (a) Burial (b) Date thereof 1 31 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd

18 (a) Funeral director Dipel Bros
(b) Address 1800 E Lombard St

19 (a) [illegible] 27 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 1948 at 7 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-17-19 48 to 1-29 19 48 and that I last saw h[illegible] alive on 1-29 19 48

Immediate cause of death: Acute Congestion pulmonary
Due to chronic disease of heart. valvular
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
10 days
years

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. Demarco M. D.
Address Medical Arts Bldg Date signed 1-29-48

Please write plainly, with ink. Every item on both sides of certificate should be answered. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

G59645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1228

G59645 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Eight St.
(c) Hospital or institution: So Balti Gen. Hospl.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1326 Sargeant St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth McCauley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
F	W	W

6 (b) Name of husband or wife Edward McCauley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13th 1867

8. AGE: Years	Months	Days	If less than one day
80	8	16	hr. min.

9. Birthplace Westminster Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Amos Koontz
13. Birthplace Md.

MOTHER
14. Maiden Name Savilla Stoner
15. Birthplace Md.

16 (a) Informant Leonard Shrubrooks
(b) Address 1326 Sargeant St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Glen Haven
Location Glenburnie Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 JAN 31 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/29 1948, at 12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/17 1947, to 1/29 1948, and that I last saw her alive on 1/29/1948.

Immediate cause of death	Duration
Due to Gastro-intestinal	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Gastro intestinal obstruction
of autopsy:

PHYSICIAN
Underline the one to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gilbert M. Carouge M. D.
Address 1213 Eight St Date signed 1/29/48

VS 150

G59646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G59646

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2617 E. Preston Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2617 E. Preston Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Henry (Harry) H. Keefer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	divorced

6 (b) Name of husband or wife Lillian Krohl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1872

8. AGE: Years	Months	Days	If less than one day
75	4	22	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Stage Director
11. Industry or business Retired

FATHER
12. Name John W. Keefer
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Francis Hubbard
15 Birthplace Baltimore, Maryland

16 (a) Informant Andrew J. Keys
(b) Address 2617 E. Preston Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 2/2/48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) JAN 31 1948 (Date rec'd by registrar) (b) Interment or Removal

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29, 1948, at 3 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15 1934 to 1/29 1948 and that I last saw h[illegible] alive on 1/28 1948

Immediate cause of death: arteriosclerotic C.V. Disease with myocardial Decompensation — Duration: 6 mos.
Due to
Due to
Other Condition Arthritis Deformans — 20 years
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Hart Grossman, M.D.
Address 212 N. Patterson Pk Ave Date signed 1/29/48

VS 150

Please write plainly, with unfading ink. Every item of information should be carefully searched. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C59647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. C59647

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1823 Whitmore Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1823 Whitmore Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Bowles Wertz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband Harry Wertz (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 20th 1876

8. AGE: Years 71 | Months 2 | Days 9 | If less than one day hr. min.

9. Birthplace Brooklyn N.Y.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name Robert Berry Lethbridge
13. Birthplace Brooklyn N.Y.

MOTHER
14. Maiden Name Alice C. Savage
15. Birthplace New Haven Conn.

16 (a) Informant Anna Wertz
(b) Address 1823 Whitmore Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/2/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 JAN 31 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29th 1948, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1937, to Jan 29 1948, and that I last saw her alive on Jan 29 1948.

Immediate cause of death	Duration
decompensating cardio-renal vascular disease	10 yrs -
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lewis Schneider M. D.
Address 1101 N. Wolfe St Date signed 1-30-48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G59648

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 201 E. Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles W. Everett

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-18-6835

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband~~ or wife Myssa Everett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 11th 1900

8. AGE: Years	Months	Days	If less than one day
48	0	17	hr. min.

9. Birthplace Westernport, Md.
(Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Carlton R.R.

FATHER
12. Name Chas. E. Everett
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah V. Blackburn
15. Birthplace Md.

16 (a) Informant Robert A. Halmick
(b) Address 1416 W. Fayette St.

17 (a) Burial (b) Date thereof 2/2/48
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) JAN 31 1948 Lexington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-29-48 19 , at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-27 1948 to 1-29 1948, and that I last saw him alive on 1-29 1948.

Immediate cause of death	Duration
Coronary occlusion + cardiac failure	
Due to Coronary Sclerosis	
Due to	
Other Conditions Hypoglycemia due to possible pancreatic adenoma	

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. L. Jamison
Address Univ. Hosp. Balto. Md. Date signed 1-29-48 M D

VS 150

C59649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C59649

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ. Hosp.
(c) Hospital or institution: Greene & Lombard Sts.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ebenezer Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John J. Eurice.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Elizabeth Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6th, 1883

8. AGE: Years 64 | Months 8 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Co., Md.
(Town, county, and state)

10. Usual Occupation Airplane Assembly

11. Industry or business

FATHER
12. Name Joseph Eurice
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Elisabeth Winkler
15. Birthplace Balto. Co., Md.

16 (a) Informant Mrs. John J. Eurice
(b) Address Box 159, Rt. 14, Balto. 20, Md.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Feb. 2, 1948 (month) (day) (year)
(c) Cemetery or crematory St Joseph's
Location Balto Co. Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Road

19 JAN 31 1948 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-30 19 48, at 1:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-26 19 48 to 1-30 19 48 and that I last saw h[illegible] alive on 1-30 19 48.

Immediate cause of death Cardiac failure

Due to possible [illegible]

Due to bronchopneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard E. Hall M. D.
Address Univ. Hosp. Date signed 1-30-48

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G59650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59650

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4001 Glenmore Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CORNELIA ENGLAND

3 (b) If veteran, name war	3 (c) Social Security Account No. 212-22-1466

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife William J. England
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7th, 1916

8. AGE: Years	Months	Days	If less than one day
32		23	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Hoschild Kohn & Co.

FATHER
12. Name John C. Vlieger
13. Birthplace Holland

MOTHER
14. Maiden Name Marcia Wilcoxson
15. Birthplace Frederick County, Md.

16 (a) Informant Mr. William J. England
(b) Address 4001 Glenmore Ave.

17 (a) burial (b) Date thereof 2/3/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Lasach Funeral Home
(b) Address 7401 Belair Road

19 (a) JAN 31 1948 (b) Lester for Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30, 1948, at 11.25 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral hemorrhage, spontaneous

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Reyle M.D.
Medical Examiner.
Date signed 1-30-48

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correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C59651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170 C

Registered No. C59651

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 4 2 hrs.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 304 Myrtle Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James DARE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 61 | Months | Days | If less than one day: hr. min.

9. Birthplace: Balto (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: John Dare
13. Birthplace: md

MOTHER
14. Maiden Name: Annie Johnson
15. Birthplace: Md

16 (a) Informant: Annie Poulson
(b) Address: 1404 Riggs Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan 31-48 (month) (day) (year)
(c) Cemetery or crematory: Mt Calvary
Location

18 (a) Funeral director: James A Sayus
(b) Address: 142 Wilkins Ave

19 (a) JAN 31 1948 (Date rec'd by registrar) (b) Funeral for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 27, 1948, at 11.40 a. M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH*: Rupture of liver.
Intra abdominal hemorrhage
Fractured ribs.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-27-48 9.30 a. M. 4/1
(b) Where did injury occur? Howard & Mulberry St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Pedestrian-struck by auto

23. Signature: George H. Merrill M.D. Medical Examiner.
Date signed 1/27/48

VS 151

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59652

JL - 87003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1931

Registered No. G59652

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1243 N. Bond St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Benjamin McLilly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1885

8. AGE: Years	Months	Days	If less than one day
62	10	21	hr. min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Richard

13. Birthplace S. C.

MOTHER 14. Maiden Name Louis ?

15. Birthplace S. C.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 31 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem.

Location A. A. Co. Md.

18 (a) Funeral director Robert E. Williams

(b) Address 1515 Mc Elderry St.

19 (a) JAN 31 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27 1948, at 8.25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 17, 1944 to Jan. 27 1948, and that I last saw h. im alive on Jan. 27 1948.

Immediate cause of death	Duration
Bronchopneumonia	2wks
Due to	
Due to	
Other Conditions Hypertensive Cardiovascular Disease	yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: a clone

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. E. Robinson Jr

Address Balt City Hosp Date signed 1/31/48 M. D.

VS 150

107

659653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Thomas 1312

Registered No. 659653

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 83 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2520 McCulloh
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Thomas
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	N	Widowed

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years	Months	Days	If less than one day
83			hr. min.

9. Birthplace Calvert Co Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name James Thomas
13. Birthplace Calvert Co Md

MOTHER
14. Maiden Name Margaret Hollyd
15. Birthplace Calvert Co Md

16 (a) Informant Bessie J. Thomas
(b) Address 2417

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 30/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Wm Brooks
(b) Address 1463 N. Carey St

19 (a) JAN 31 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/27 19 48 at 10 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/22 19 48 to 1/27 19 48, and that I last saw h[illegible] alive on 1/27 19 48.

Immediate cause of death Cerebral Thrombosis

Due to Hypertensive C-V Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Preston Grant M. D.
Address 1514 Division Date signed 1/28/48

VS 150

G59654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59654

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 759 W. Saratoga St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs.) mos., or days) 30

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 759 W Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Atkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife James Atkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/10/1881

8. AGE: Years 66 | Months 6 | Days 18 | If less than one day hr. min.

9. Birthplace Virginia (town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Eli Veney

13. Birthplace Va.

MOTHER 14. Maiden Name Mary J Thompson

15. Birthplace Va

16 (a) Informant Evelyn Brooks

(b) Address 759 W. Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof - - 48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location A. A. Co., Md.

18 (a) Funeral director Isaiah L. Brown & Son

(b) Address 108 W. Montgomery St

19 (a) JAN 31 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-28 1948, at 0257 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948, to Jan 28 1948, and that I last saw h alive on 19

Immediate cause of death	Duration
Lobar Pneumonia Rt lower lobe	2 days
Due to Bronchial asthma	4 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm R Johnson M.D.

Address 403 Med Arts Bldg Date signed 1-29-48

VS 150

G59655 C 92305

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G59655 Registered No. 109a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. 35 W. Cross (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Beatrice Blanford

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10/26/48

8. AGE: Years	Months	Days	If less than one day
	3	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Thomas Blanford
13. Birthplace Florida

MOTHER
14. Maiden Name Isadora Blanford
15. Birthplace md

16 (a) Informant Isadora Blanford
(b) Address 35 W Cross St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balt Cty

18 (a) Funeral director Squab & Brownstein
(b) Address 10 E Monument St

19 (a) JAN 31 1948 (Date rec'd by registrar) (b) Huntington Wilkinson, Registrar, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29 1948 at 12:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-27 1948 to 1-29 1948 and that I last saw h[illegible] alive on 1-29 1948

Immediate cause of death Respiratory failures — Duration

Due to Diffuse pneumonitis

Due to

Other Conditions Dehydration & Acidosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert C. Hunter, M.D. M. D.
Address Univ. Hosp. Date signed 1-29-48

VS 150

G59656
AB-115454

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

Registered No. G59656

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1835 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter E. Woodall

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-05-5348

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Catherine G. Woodall (nee Welsh)
6 (c) If alive, give age 58 years
7. Birth date of deceased (mo., day, yr) Dec. 23- 1882

8. AGE: Years	Months	Days	If less than one day
65	1	5	hr. min.

9. Birthplace Md., Baltimore (Town, county, and state)
10. Usual Occupation Pgs Laborer
11. Industry or business Locke-Insulator Corp

FATHER
12. Name John Woodall (D
13. Birthplace Md.

MOTHER
14. Maiden Name Carolyn ? (D
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospital
(b) Address 4940 Eastern Ave. and wife

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sat., Jan. 31, 1948 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem.
Location a a co md.

18 (a) Funeral director C. Howard Evans
(b) Address 1400 S. Charles St (30)

19 JAN 31 1948 (Date rec'd by registrar) Lentz for Williams MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28 - 1948, at 6.10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-25- 1947 to 1-28- 1948, and that I last saw him alive on 1-28- 1948.

Immediate cause of death Far-advanced bilateral pulmonary tuberculosis with constation — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William H. Kushlan MD
Address Balto City Hosp Date signed 31 Jan 48

VS 150

659657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. 659657

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4618 Bowleys Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Healy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Jan 28. 1948

8. AGE: Years | Months | Days | If less than one day hr. (?)5 min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Anatus J Healy Jr
13. Birthplace Md

MOTHER
14. Maiden Name Ruth Ky (Unknown)
15. Birthplace Md

16 (a) Informant Anatus J Healy Jr
(b) Address 4618 Bowleys Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore Md

18 (a) Funeral director Wilhelm & Son
(b) Address 219 E Fort Ave

19 (a) JAN 31 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28, 1948, at 5 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ? at ? M.
(b) Where did injury occur? 4618 Bowleys Lane
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Undetermined

23. Signature Paul L Ryan M.D.
Medical Examiner
Date signed 1-28-48

VS 181

X

G59658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59658

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da

(e) Length of stay in Baltimore (yrs., mos., or days) 5 da

2. USUAL RESIDENCE OF DECEASED:

(a) State Texas (b) County

(c) City or town Beaumont (If outside city or town limits, write RURAL and give town)

(d) Street No. 2360 Delaware Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Patricia Walling

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-27-42

8. AGE: Years	Months	Days	If less than one day
5	5	3	hr. min.

9. Birthplace Texas (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Harold Walling

13. Birthplace Okla.

MOTHER — 14. Maiden Name Gertrude Swan

15. Birthplace Texas

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 4, 1948 (month) (day) (year)

(c) Cemetery or crematory Beaumont

Location Texas

18 (a) Funeral director Walter Burdge Bradley

(b) Address 822 W. North Avenue

19 JAN 31 1948 Huntington Williams Registrar (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-30 1948, at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-26 1948 to 1-30 1948, and that I last saw her alive on 1-30 1948.

Immediate cause of death	Duration
Cardiac Failure	Sudden
Due to Congenital Heart Disease	5 yrs
Due to Transposition of the Great Vessels	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 0

Major findings of operation: 0

Site of autopsy: Transposition Great Vessels

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature James R Cantrell M. D.

Address The Johns Hopkins Hosp Date signed Jan 31 48

Ailes

G59659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 937

Registered No. G59659

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3207 Hamilton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 W
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3207 Hamilton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis G. Ailes.

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-9912

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Laura J. Ailes

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Jan 12 1883

8. AGE: Years 65 | Months 0 | Days 19 | If less than one day hr. min.

9. Birthplace York Co. Pa
(Town, county, and state)

10. Usual Occupation Erecting Foreman

11. Industry or business Steel Construction

FATHER
12. Name Wm. E Ailes
13. Birthplace Lancaster Co. Pa

MOTHER
14. Maiden Name Martha J. Carrick
15. Birthplace Phila Pa

16 (a) Informant Laura J. Ailes
(b) Address 3207 Hamilton Ave Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 4. 1948 (month) (day) (year)
(c) Cemetery or crematory Glatonville
Location Delta, Pa

18 (a) Funeral director Herbert P Harkins
(b) Address Delta, Pa.

19 (a) JAN 31 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31 1948, at 7.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 29 1948 to Jan 31 1948 and that I last saw him alive on Jan 30 1948

Immediate cause of death Pulmonary Edema — Duration 1 Hr

Due to Coronary Thrombosis — 2 Hrs

Due to Hypertension C.V.D.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Harry Hoen

Address 4718 Roland Rd. Date signed: M. 1 D. 31 48

VS 150

G59660

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G59660

1. **PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3008 Harlem Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. **USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3008 Harlem ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elizabeth Black

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife William T.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1883

8. AGE: Years 64 | Months 6 5 | Days 4 5 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Burkhart
13. Birthplace Pittsburgh

MOTHER
14. Maiden Name Loretta Powell
15. Birthplace Pittsburgh

16 (a) Informant James Black
(b) Address 3008 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-2-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Fulton Ave - Forrest St

19 (a) Jan 31 1948 (Date filed by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. **DATE OF DEATH** Jan 30 19 48, at 2 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1948, to Jan 30 1948 and that I last saw h.e. alive on Jan 29 1948.

Immediate cause of death	Duration
Cardiac Failure	
Due to Cerebral Hemorrhage	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Scarpetta M. D.

Address 1724 W. Lombard St Date signed 1/31/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59661 GK. 115027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46 ff

Registered No. G59661

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Months
(e) Length of stay in Baltimore (yrs., mos., or days) 49 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 408 Avondale RD.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Brown Macon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife Sydney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 30 - 1898

8. AGE: Years	Months	Days	If less than one day
49 40	8	29	hr. min.

9. Birthplace VA.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Wright
13. Birthplace VA.

MOTHER
14. Maiden Name Mahalia Brown
15. Birthplace VA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Jan 31 1948 (month) (day) (year)
(c) Cemetery or crematory Fredericksburg
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Lemmon Hill Ave.

19 (a) JAN 31 1948 (Date rec'd by registrar) Clinton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - 29 - 1948, at 2.55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 - 5 - 1947 to Jan. 29 1948, and that I last saw her alive on Jan. 29 - 1948

Immediate cause of death Hodgkins sarcoma Duration
~~Carcinomatosis, primary, site undetermined~~ ?
~~Retroperitoneal lymphnodes~~ & metastases
Pathological fracture ?
Due to 12th Dorsal & 1st Lumbar vertebrae

Other Conditions Hemorrhagic Cystitis ?
& Pyelonephritis
(Include pregnancy within 3 months of death)

Date of operation Dec 6, 1947

Major findings of operation: Carcinoma of Cervical Lymph Node

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ruth E. Nutterville M. D.
Address Balt. City Hosp. Date signed Jan 30 1948

VS 150

659662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 659662

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3629 Leo St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3629 Leo St. Wagner's Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paulina Brzuchalski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Stanislaw

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 84 | Months | Days | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

MOTHER FATHER

12. Name Julius Phillips

13. Birthplace Poland

14. Maiden Name Wilhemina Betner

15. Birthplace Poland

16 (a) Informant Stella Blachowicz

(b) Address 3831 E. Monument

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 2-48 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Balto Co.

18 (a) Funeral director Wm. L. Trialkowski

(b) Address 2007 Eastern Ave

19 (a) JAN 31 1948 (Registrar's signature) Registrar for Williams M.D. Registrar

MEDICAL CERTIFICATION 6.40

20. DATE OF DEATH 1/29/48 19 , at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/28/ 1948 to 1/29/ 1948 and that I last saw her alive on 1/28/ 1948

Immediate cause of death	Duration
Congestive heart failure,	
arterio sclerotic hyper-	
Due to tensive heart disease.	?
Due to	
Other Conditions - - - -	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Lantz M. D.

Address 1226 Hanover St. Date signed 1/31/ 1948

VS 150

G59663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G59663 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bettye Price

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	cd	Married

6 (b) Name of husband or wife Albert C. Price
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-20-1920

8. AGE: Years	Months	Days	If less than one day
23	4	2	hr. min.

9. Birthplace Millwood Va.
(Town, county, and state)
10. Usual Occupation Waitress
11. Industry or business

FATHER
12. Name John Jones
13. Birthplace Boyce, Va.

MOTHER
14. Maiden Name Ann Stuffard
15. Birthplace Millwood, Va.

16 (a) Informant Mrs. Ann Jones
(b) Address 1305 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-31-1948 (month) (day) (year)
(c) Cemetery or crematory Loving Charity
Location Millwood, Va.

18 (a) Funeral director Wm. Geo. H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) 240 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30, 1948, at 3:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-21 1947 to 1-30-1948, and that I last saw her alive on 1-30-1948.

Immediate cause of death	Duration
Probable Miliary Tbc.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Higgins M. D.
Address 2243 Madison Ave. Date signed 1/31/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G59664 (Registered No.)

G59664

1. PLACE OF DEATH: West Baltimore General 1548
(a) Baltimore City, Maryland
(b) Street address: Dukeland & Rayner Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 15 D
(e) Length of stay in Baltimore (yrs., mos., or days): 40 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 2315 W North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country:

3 (a) FULL NAME: Israel Talles

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rachel

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1877

8. AGE: Years: 70 Months: Days: If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: None

11. Industry or business:

FATHER
12. Name: Aaron Talles
13. Birthplace: Russia

MOTHER
14. Maiden Name: Unkown
15. Birthplace: Russia

16 (a) Informant: Eli Talles
(b) Address: 4024 Bonner Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 1, 1948 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Rosedale Cemetery
Location: Hamilton Ave

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Registrar: [illegible]

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/31 1948, at 2:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/20 1948 to 1/31 1948 and that I last saw h[illegible] alive on 1/31 1948.

Immediate cause of death — Coronary Thrombosis

Due to: ASCVD

Due to:

Other Conditions: Pulmonary Edema

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Nathan Levin M. D.
Address: WBGH Date signed: 1/31/48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G59665 F6331 108 G59665 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 125 N. Denison St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Joan K. Bond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 24,1942

8. AGE: Years	Months	Days	If less than one day
5	1 2	7	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER | FATHER

12. Name Charles S. Bond
13. Birthplace Baltimore, Md.
14. Maiden Name Clara E. Brandt
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Charles S. Bond
(b) Address 125 N. Denison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 2,1948 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Miller & Lawrence
(b) Address 4510 Liberty Heights Ave.

19 (a) (Date rec'd by Registrar) (b) Registrar

FEB 1 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31 1948; at 6.05A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1943 to Jan 31 1948, and that I last saw her alive on Jan 30 1948.

Immediate cause of death Pulmonary Edema — Duration 2 days
Due to Epilepsy - Retardat — Coll Cyst
Mentality & Hysterectomy
Due to Birth Injury
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eliot W. Schumm M. D.
Address 3432 Frederick Ave Date signed 1/31/48

X

G59666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

104

Registered No. G59666

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 730 E. Pratt St. Room 15. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME THEODORE R. COOK

3 (b) If veteran, name war	3 (c) Social Security Account No.
W. W. I	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Maulow W. Va. (Town, county, and state)
10. Usual Occupation Riveting Porter
11. Industry or business Brundell Corp.

FATHER
12. Name Silas M. Cook
13. Birthplace New Market, Va.

MOTHER
14. Maiden Name Julia Ford
15. Birthplace Virginia

16 (a) Informant Mrs Harry Cook
(b) Address Maulow W. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 2 1948 (month) (day) (year)
(c) Cemetery or crematory Cemetary
Location Maulow W. Va.

18 (a) Funeral director Edith V Seat
(b) Address Williamsport Md

19 (a) FEB 1 1948 (Date rec'd by registrar) (b) Registrar

Remington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1948, at 4:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Lobar Pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl V Royer M.D.
Medical Examiner.
Date signed 1-26-48

VS 151

X

G59667 GM. 116547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G59667 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 15 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 32 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 727 S. Charles ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carey Dorsey Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Charles Walker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March - 22 - 892

8. AGE: Years	Months	Days	If less than one day
55 ?	10	6	hr. min.

9. Birthplace VA. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Read
13. Birthplace VA.

MOTHER
14. Maiden Name Melinda ?
15. Birthplace VA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Balto City

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W. Montgomery St Huntington Williams, Md

19 (a) (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28 - 1948, at 5.00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-13- 1948, to 1-28-48 1948, and that I last saw her alive on Jan. 28 1948.

	Duration
Immediate cause of death Bronchopneumonia	2 days
Due to Intertrochanteric fracture of femur, left.	5 wks
Due to	
Other Conditions ASCVD	yrs

(Include pregnancy within 3 months of death)

Date of operation 1/14/48
Major findings of operation: Fracture of femur
of autopsy: bronchopneumonia, CPC of Lung

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 22/1
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 1/13/48 at 10 A.M.
(c) Where did injury occur? Balt (City or town) Balt (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Foot tripped on rug & fell

23. Signature Gordon Read M. D.
Address Balt City Hosp. Date signed 1/29/48

FEB 1 1950

To be approved by Medical Examiner

WILLIAM G. HELFRICH, M.D.
PER: Howard J. Malden, M.D.

G59668

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G59668 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5007 Grindon ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5007 Grindon ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Anna Peters

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Edward Peters deceased
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1-1873

8. AGE: Years 74 | Months 5 | Days 27 | If less than one day: hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Dohmeyer
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Catherine Peters
(b) Address 5007 Grindon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Geo L Beyer Jr
(b) Address 1512 Hollins St

19 (a) 1948 (Date rec'd by registrar) (b)
Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 1948, at 10:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1946 to Jan 28 1948 and that I last saw h[illegible] alive on 27 Jan 1948

Immediate cause of death: Hypertensive Cardio-Vascular disease — Duration: 1 year
Due to: Cardiac failure — 3 wks
Due to: Senility —
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James E. Hurley M. D.
Address 5214 Harford Rd signed 31 Jan 48

VS 150

G59669

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G59669 Registered No.

46F

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2835 Boarman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jacob Frank

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 65 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Isaac
13. Birthplace Russia

MOTHER
14. Maiden Name Esther
15. Birthplace Russia

16 (a) Informant Ann Frank
(b) Address 2835 Boarman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men
Location Woodlawn Milk Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 2400 Eutaw Place

FEB 1 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 Jan 1948, at 2:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1948 to 31 Jan 1948, and that I last saw him alive on 31 Jan 1948.

Immediate cause of death: Cardiorespiratory failure — Duration: One day
Due to: Peritonitis — Duration: One week
Due to: Recent operation
Other Conditions: Carcinoma of ampulla of Vater (Include pregnancy within 3 months of death)
Date of operation: 7 January 48
Major findings of operation: Carcinoma of Ampulla of Vater
of autopsy: Peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Myron Myers M. D.
Address Sinai Hospital Date signed 31 Jan 48

X

G59670 Foss X G59670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Elizabeths Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Waldorf

2. USUAL RESIDENCE OF DECEASED: 2
(a) State D.C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 26 Buchanan St. N.E. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Foss

3 (b) If veteran, name war: W.W. #2
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Beulah M
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 29 1917
8. AGE: Years 30 (31) Months 7 Days 2 If less than one day hr. min.
9. Birthplace Chicago Ill (Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business U.S. Government

FATHER
12. Name Walter T. Foss
13. Birthplace Chicago Ill

MOTHER
14. Maiden Name Bessie E. Stoddard
15. Birthplace Chicago Ill

16 (a) Informant Robert T. Foss
(b) Address 26 Buchanan St. N.E.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-4-48 (month) (day) (year)
(c) Cemetery or crematory Arlington National
Location Washington D.C.

18 (a) Funeral director Wm Cook Inc.
(b) Address 1317 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 Jan 1948, at 11:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Concussion
Ruptured Liver
Due to
Other Conditions Front. left + tib + fibula fractures of Rib.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 31 Jan at 8:15 P.M. Baltimore
(b) Where did injury occur? Work Blvd. 1 mile N. Pimlico Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Car collided + truck

23. Signature Earl L Rogers M.D. Medical Examiner.
Date signed 1 Feb 48

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59671 JL - 116344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G59671

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 61
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 118 N. Ellwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Emma Rauh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1879

8. AGE: Years 68 | Months 2 | Days 10 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Phillip Wolf
13. Birthplace Germany

MOTHER
14. Maiden Name Eva [illegible] Unknown
15. Birthplace Germany

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director John A. Wilson
(b) Address 3000 E. Balto. St.

19 FEB 1 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29 19 48 at 8.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 5 1948, to Jan. 29 1948, and that I last saw her alive on Jan. 29 1948.

	Duration
Immediate cause of death Carcinoma Left Breast with Axillary metastases	
Due to Bilateral Pulmonary Caseous Tuberculosis	years
Due to Cystitis, Left	years
Other Conditions	?

(Include pregnancy within 3 months of death)

Date of operation Jan 5, 48

Major findings of operation: Carcinoma of Breast, Left

of autopsy: See Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hugh D. Tattersall M. D.
Address Balt City Hosp. Date signed Jan 30 1948

VS 150

G59672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

G59672 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1238 West Cross St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give County)
(d) Street No. 1238 W. Cross St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cecel Machumowitz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Mendel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 63 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Moetoz

13. Birthplace Russia

MOTHER 14. Maiden Name Lazah

15. Birthplace Russia

16 (a) Informant Mrs Sol Baker

(b) Address 901 Washington Boulevard

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-48 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Phila. Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 2100 Eutaw Place

19 (a) FEB 1 1948 (Date rec'd by registrar) (b) Washington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-31- 1948, at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 20 1947, to Jan 31 1948, and that I last saw h.e alive on Jan 31, 1948.

Immediate cause of death: Chronic Myocarditis — Duration: 9 mos.

Due to Arteriosclerotic Cardio Vascular Disease.

Due to

Other Conditions Hemiplegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel B Wolfe M. D.

Address 1331 E. North Ave Date signed 1-31-48

VS 150

G59673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

10 1B

G59673
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens Ave.
(c) Hospital or institution:
St. Agnes Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1132 Sulphur Spring Rd 27
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Applegate.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W	Wd.

6 (b) Name of husband or wife Catherine L.
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) 2/3/1880

8. AGE: Years	Months	Days	If less than one day
67	11	27	hr. min.

9. Birthplace Wisconsin
(Town, county, and state)

10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Alfred Applegate.
13. Birthplace Dec'd. New Jersey

MOTHER
14. Maiden Name Nancy Duchien Dec'd
15. Birthplace Wis.

16 (a) Informant Mrs. Schmidt
(b) Address 1132 Sulphur Spring Rd

17 (a) Burial (b) Date thereof 2/3/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto City.

18 (a) Funeral director F. B. Wisheart & Son
(b) Address 200 Eutaw Rd 7

19 (a) FEB 1 1948 Thomas Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-30 1948 at 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1948 to Jan 30 1948 and that I last saw h.. alive on Jan 30 1948

Immediate cause of death
Pulmonary Embolism (Coma)
Due to Phlebothrombosis Left
Due to Femoral
Other Conditions B.H. Prostate.
C.P.C.
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: Pulmonary embolism

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alfred Hanson
Address St. Agnes Hosp Date signed 1/30/48
M.D.

VS 150

G59674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G59674

Registered No.

OC - 49-01996 / 157E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton & Wilkens

(c) Hospital or institution: St. Agnes 25.2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 31.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County U. Sol.

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1025 Wilmington Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Reed - Frances E. Reed "

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28-48

8. AGE: Years — Months — Days 3da. If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name George Reed

13. Birthplace Baltimore

MOTHER

14. Maiden Name Gertrude Norfolk

15. Birthplace Va.

16 (a) Informant George B. Reed

(b) Address 1025 Wilmington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/48 (month) (day) (year)

(c) Cemetery or crematory Mount Cathedral

Location Woodlawn Cem.

18 (a) Funeral director F. B. Wappert & Son

(b) Address 1300 Eastern Ave

19 (a) (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/31 1948, at 1.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-28 1948, to 1-31 1948, and that I last saw h. ex alive on 1-31 1948.

Immediate cause of death Congenital heart disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Congenital Heart disease

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Jose G. Valdivia M. D.

Address St Agnes' Hosp. Date signed 1-31-48

VS 150

X

G59675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G59675

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 342 S. Clinton St.
(c) Hospital or institution: 26-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 342 S. Clinton St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Wilhelmina H. Sanders

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William J. Sanders
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1882

8. AGE: Years	Months	Days	If less than one day
65	5	21	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Bonaventure Kroneung
13. Birthplace Germany

MOTHER
14. Maiden Name Anna ?
15. Birthplace Germany

16 (a) Informant William J. Sanders
(b) Address 342 S. Clinton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 2 48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4900 Belair Road

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. Wolfe St, Balto. 31.

19 (a) FEB 2 1948 (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

VS 19 14 16

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Jan. 30th. 1948, at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug - 1930 to Jan 30 1948, and that I last saw her alive on Jan 30 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage (Last)	1948
Hypertension	1942
Due to Arteriosclerosis	1942
Pernicious Anemia	1930
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. J. Zeiler M. D.
Address 3426 Bank Date signed 1/31/48

G59676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G59676

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min

(e) Length of stay in Baltimore (yrs., mos., or days) 6

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Carroll

(c) City or town Westminster,
(If outside city or town limits, write RURAL and give town)

(d) Street No.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Carroll H. Hogue

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1881

8. AGE: Years	Months	Days	If less than one day
66 67	7	4 3	hr. min.

9. Birthplace Westminster Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Andrew Hogue

13. Birthplace Westminster

MOTHER

14. Maiden Name Mary Ward

15 Birthplace Westminster

16 (a) Informant Daughter

(b) Address Westminster

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 5 1948 (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director John R. Byers

(b) Address Westminster Md.

19 FEB 2 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2 1948, at 12 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1948 to 2/2 1948, and that I last saw him alive on 2/2 1948.

Immediate cause of death	Duration
Cerebral embolism?	
Due to (Secondary to Pneumonia)	
Due to	over
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?

(e) Means of injury

23. Signature H. C. Hogue

Address Mercy Hosp. Date signed 2/2/48 M. D.

VS 190

X

G59677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G59677

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 25-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2404- Dorton Court.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT BORN

3 (b) If veteran, name war: Spanish Amer.

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife BERTHA SMITH

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 78 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace HAGERS TOWN, MD.
(Town, county, and state)

10. Usual Occupation STREET DEPT.

11. Industry or business BALTIMORE, MD

FATHER
12. Name CALVIN BORN
13. Birthplace HAGERSTOWN, MD

MOTHER
14. Maiden Name JULIE BOWERD
15. Birthplace HAGERSTOWN, MD

16 (a) Informant WALTER KENNETH BORN
(b) Address 2404 DORTON COURT

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2 3 48 (month) (day) (year)
(c) Cemetery or crematory GLEN HAVEN
Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST.

19 (a) FEB 2 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31, 1948, at 7.50 a M

21. I certify that I took charge of the remains described above, held an insp& inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C. V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Kay M.D.
Medical Examiner.

Date signed 1-31-48

VS 151

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59678

G59678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 913. Burgundy St.
(c) Hospital or institution: 21-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 913. Burgundy St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Emma Marie Fischer (Brecklein)

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John B. Fischer

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Feb 23, 1881

8. AGE: Years 78 | Months 11 | Days 6 | If less than one day ..... hr. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Mrs Anna K. Smith
(b) Address 526 Ashburton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Frederick Rd.

18 (a) Funeral director John F Denny Sons
(b) Address 747 Light St.

19 (a) FEB 2 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29th 1948 at 7:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 to Jan. 29 1948.
and that I last saw h alive on 1/29 1948.

Immediate cause of death Cardio-Renal Vascular — Duration 7 years
Due to Decease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benj. Samuels M.D.
Address 2128 W. Fayette Date signed 1/30/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

59679. Octavius Devone 59679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 640 W. Saratoga St
(c) Hospital or institution: 4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2d

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 640 W. Saratoga st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Octavius Devone one

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Sarah Devone
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Fayetteville N.C. (Town, county, and state)
10. Usual Occupation Longshoreman
11. Industry or business

FATHER
12. Name William Clarkdale
13. Birthplace N.C.

MOTHER
14. Maiden Name Dollie Devone
15. Birthplace N.C.

16 (a) Informant Sarah Devone
(b) Address 640 W Saratoga st

17 (a) (Burial, cremation, or removal) (b) Date thereof 2/2/48 (month) (day) (year)
(c) Cemetery or crematory Chapel Grove
Location Fayetteville N.C.

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania Ave

19 (a) Date received by Registrar FEB 2 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Jan 1948, at 12:15 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tuberculosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil Rogen M.D.
Medical Examiner.
Date signed 1 Feb 48

VS 151

G59680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43a

Registered No. G59680

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution: Sinai Hospital 194
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore 30 (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 McHenry St-23
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry T. Adams

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife: ✓
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 12-1910
8. AGE: Years 37 Months 5 Days 19 If less than one day hr. min.
9. Birthplace Dobs - Maryland
(Town, county, and state)
10. Usual Occupation Attendant
11. Industry or business Sinai Hospital

FATHER
12. Name Harry C Adams
13. Birthplace Dobs - Md

MOTHER
14. Maiden Name Bessie M. Riley
15. Birthplace London County Va.

16 (a) Informant Mrs Bessie Hill Maddox
(b) Address 1815 McHenry St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-48 (month) (day) (year)
(c) Cemetery or crematory London Park Cemetery
Location Frederick Rd.
18 (a) Funeral director Milton Schilling
(b) Address 3914 Hanover St-25
19 (a) FEB 2 1948 (Date received by Registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/31 1948, at 7 25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/30 1948, to 1/31 1948, and that I last saw him alive on 1/31 1948.

Immediate cause of death: Strangulation by Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Strangulation by Hem.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address Date signed 1/31/48 M. D.

VS 150

X

G59681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. G59681

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 4-1
(b) Street address
(c) Hospital or institution: MERCY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 5 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 122 N. CALVERT (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME OHLEY GRAHAM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) ~~Single~~, married, ~~widowed, or divorced~~. M

6 (b) Name of husband or wife FRANCES GRAHAM

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 1, 1890

8. AGE: Years 57 Months 5 Days 0 30 If less than one day ..... hr. ..... min.

9. Birthplace MASONTOWN, W. VA. (Town, county, and state)

10. Usual Occupation FEDERAL GOVT

11. Industry or business Social Security Board

FATHER 12. Name SHERMAN GRAHAM

13. Birthplace MASONTOWN, W. VA.

MOTHER 14. Maiden Name MARTHA HARTLEY

15. Birthplace W. VA.

16 (a) Informant ADM. SLIP

(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/2/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Beverly Hills

Location Morgantown W. Va.

18 (a) Funeral director Williams Cook Inc.

(b) Address 1017 St. Paul St.

19 (a) FEB 2 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 31 1948, at 6:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 15 1948 to JAN 31 1948 and that I last saw h, m alive on 1/31 1948.

Immediate cause of death CARDIAC FAILURE

Due to RHEUMATIC HEART DISEASE

Due to PULMONARY INFARCT

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: RHEUMATIC HEART

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elden H. Pratt

Address Mercy Hosp. Date signed 9/31/48

X

059682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163H

Registered No. 059682

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3908 N. Charles St
(c) Hospital or institution: 12-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Claude M. Gray

3 (b) If veteran, name war W.W. #1

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Gladys M. Gray

6 (c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.) Sept 25 1890 (Sept 25 = 1890)

8. AGE: Years 57 | Months 3 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace: Rockville Ind.
(Town, county, and state)

10. Usual Occupation: President

11. Industry or business: Balto. Transit Co.

MOTHER

12. Name: Ella Brown

13. Birthplace: Indiana

FATHER

12. Name: Lawrence O. Gray

13. Birthplace: Indiana

16 (a) Informant: Gladys M. Gray

(b) Address: 3908 N. Charles St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/2/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~: Highland Lawn

Location: Terre Haute Indiana

18 (a) Funeral director: William Cook Inc.

(b) Address: 121 St. Paul St.

19 (a) FEB 2 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Feb 1948, at 7 1/2 a. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Asphyxiation

Due to: Illuminating gas

Other Conditions: Bullet wound of chest and abdomen
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 2/1/48 at 7 a. M.

(b) Where did injury occur? 3908 N. Charles St Baltimore Md

(c) Did injury occur at home, on farm, industrial place, in public place? ~~Home~~ While at work? no

(d) Means of injury ~~Gun shot wound~~ Firearm

23. Signature: Medical Examiner M.D.

Date signed 1 Feb 48

VS 151

PLEASE WRITE PLAINLY, WITH CAPPING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

59683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73a

G59683 Registered No.

PRINT NAME PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 516 E. 41ST ST.
(c) Hospital or institution: G-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 515 E. 41ST ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FRANK NOVAK

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWED

6 (b) Name of husband or wife ANNA NOVAK
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5th 1869

8. AGE: Years	Months	Days	If less than one day
79	0	26	hr. min.

9. Birthplace BOHEMIA. (Town, county, and state)
10. Usual Occupation MINISTER
11. Industry or business RETIRED

FATHER
12. Name NOVAK
13. Birthplace BOHEMIA.

MOTHER
14. Maiden Name
15. Birthplace BOHEMIA.

16 (a) Informant JOHANNA SWERPER
(b) Address 515 E. 41ST ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/3/48 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE
Location Baltimore

18 (a) Funeral director Wm Carl Lee.
(b) Address 1217 St. Paul St.

19 FEB 2 1948 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1948 11.50 AM. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948 Jan 31 1948 and that I last saw alive on Jan 31 1948

Immediate cause of death: Cerebral Arteriosclerosis — Duration

Due to

Due to

Other Conditions Pernicious Anemia.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Krause
Address 11 E. Chase St. Date signed 1/31/48

VS 150

97

G59684

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

Registered No. G59684

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2930 Independence st
(c) Hospital or institution: 9-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2930 Independence st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F. Ningard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~; widowed, or ~~divorced~~
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Catherine Ningard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27th 1870

8. AGE: Years	Months	Days	If less than one day
77	5 6	3	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Insurance

FATHER
12. Name Ningard
13. Birthplace

MOTHER
14. Maiden Name Catherine Miller
15. Birthplace Balto. Md.

16 (a) Informant G. Raymond Ningard
(b) Address 510 Richwood Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/2/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Presbyterian
Location Govans - Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st

19 (a) FEB 2 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30th 1948, at 1 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1948 to Jan 30 1948 and that I last saw him alive on Jan 30 1948

Immediate cause of death	Duration
Acute Lobar Pneumonia	10 days
Due to	
Due to	
Other Conditions Bronchitis - Arteriosclerosis (Include pregnancy within 3 months of death)	40 days

Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature John A. Hanna M.D.
Address 11 E. Chase St Date signed 1/31/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

95c

G59685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G59685 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4307 Chatham Rd

(c) Hospital or institution: 28-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimor (If outside city or town limits, write RURAL and give town)

(d) Street No. 4307 Chatham Road (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Rose Fortin

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Morris Fortin

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) 1864

8. AGE: Years 84 yrs | Months — | Days — | If less than one day — hr. — min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At home

MOTHER / FATHER

12. Name Chaim Kaminetzky

13. Birthplace Russia

14. Maiden Name Sipa

15. Birthplace Russia

16 (a) Informant (Mrs) Fay Zubin

(b) Address 1307 Chatham Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-48 (month) (day) (year)

(c) Cemetery or crematory Arlington

Location Rogers Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 2106 Eutaw Place

19 (a) FEB 2 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 1948, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1947 to Feb 1 1948.

and that I last saw h[illegible] alive on Feb 1 1948.

Immediate cause of death Arterio sclerosis

Cerebral hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Jay Kadent M. D.

Address 2306 Eutaw Pl Date signed 2-1-48

VS 150

G59686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G59686 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1919 E. Fayette St

(c) Hospital or institution: 6-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1919 E Fayette St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mary Sherr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1853

8. AGE: Years 95 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Morton

13. Birthplace Russia

MOTHER 14. Maiden Name Rifka

15 Birthplace Russia

16 (a) Informant Henry Klaff

(b) Address 3404 Howard Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-48 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Kemp Inc

(b) Address 2600 Eutaw Place

19 (a) FEB 2 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1 1948, at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1948 to Feb 1 1948 and that I last saw her alive on Jan 31 1948.

Immediate cause of death	Duration
Myocarditis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Samuel Snyder M. D.

Address 1634 E. Baltimore Date signed 2/1/48

VS 150

C59687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

C59687 Registered No.

PRESS WHITE PENCIL, WITH UNDERLINE. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 319 Birkwood Place
(c) Hospital or institution: -- 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) --

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 319 Birkwood Place (If rural give location)
(e) Citizen of foreign country? ** (Yes or No)
If yes, name country --

3 (a) FULL NAME EDWARD F. DAVIS

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: Yes

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Hilda C. Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 20, 1865

8. AGE: Years	Months	Days	If less than one day
82	6	10	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Retired-- Balto. City
11. Industry or business: --

FATHER
12. Name: Albert Davis
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Sarah Owens
15. Birthplace: Virginia

16 (a) Informant: Mrs. Hilda C. Davis--Wife
(b) Address: 319 Birkwood Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/48 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill
Location: Balto Co., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: North & Pa. Aves; Balto., Md.

19 (a) FEB 2 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30, 1948 19..., at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 10 1947, to Jan. 30 1948, and that I last saw him alive on Jan 29 1948

Immediate cause of death: Cardio Vascular disease.
Due to: Chronic Myocarditis. 1 year
Due to: Arteriosclerosis several years.
Other Conditions: Age.
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Wm Chas. C. Blake M. D.
Address: Med. Arts Bldg. Date signed 1-30-48

VS 150

G59688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

G59688 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE AND JOHN
(c) Hospital or institution: WOMENS HOSPITAL 132
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 72 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2028 MT. ROYAL TERRACE (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME VIRGINIA Gettier PORTER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife JOHN L. PORTER
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) OCT. 21, 1875

8. AGE: Years	Months	Days	If less than one day
72	3	10	..... hr. ..... min.

9. Birthplace BALTIMORE MD (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business HOME

FATHER
12. Name WILLIAM H GETTIER
13. Birthplace BALTIMORE MARYLAND

MOTHER
14. Maiden Name AMELIA (UNKNOWN)
15. Birthplace BALTIMORE MARYLAND

16 (a) Informant JOHN L. PORTER
(b) Address 2028 MT Royal

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

FEB 2 1948

19 (a) ..... (Date rec'd by registrar) Certificate from Williamsport

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 JAN. 1948, at 1 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 21 Jan 1948 to 31 Jan 1948, and that I last saw h[illegible] alive on 3 Jan 1948

Immediate cause of death	Duration
Cardiac degeneration, failure	
Due to Acute myelogenous leukemia	+ 10 Days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dan'l Blazer Jr M. D.
Address Lafayette & John Date signed 1-31-48

659689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

659689 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 W Rogers Ave. 27-15
(c) Hospital or institution:
Home For The Aged of the Methodist Ch.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Jun 1946
(e) Length of stay in Baltimore (yrs., mos., or days) 46Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 W. Rogers Ave.
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME ELIZEBETH J. BOYD

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
--	--	F	W	Widowed

6 (b) Name of husband or wife Robert H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1857

8. AGE: Years	Months	Days	If less than one day
90	2	4	hr. min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation None
11. Industry or business --

FATHER
12. Name John Clouse
13. Birthplace Penna.

MOTHER
14. Maiden Name Nancy Nuss
15. Birthplace West Virginia

16 (a) Informant Miriam O. Coates - Supt.
(b) Address Home For the Aged ot the Meth.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/48 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Western Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Ave; Balto., Md.

19 (a) (Date rec'd by registrar) (Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29, 1948, at 5:45P M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN-15 1948 to JAN 28 1948 and that I last saw her alive on 1-28 1948.

Immediate cause of death	Duration
Myocardial Insufficiency	13 days
Due to	
Due to Arterio Sclerosis	20yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Arthur J. Davies M. D.
Address 800 W 33rd St Date signed 1-31-48

VS 150

G59690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G59690 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 210 Bloomsbury Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward H. McDaniel

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Florence W. McDaniel
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Dec 13, 1879

8. AGE: Years	Months	Days	If less than one day
68	1	18	hr. min.

9. Birthplace Springfield Ohio (Town, county, and state)
10. Usual Occupation Retired Grocerymman
11. Industry or business

FATHER
12. Name Edward A. Mc. Daniel
13. Birthplace Md.

MOTHER
14. Maiden Name Oceola Powers
15. Birthplace Unknown

16 (a) Informant Florence W. Mc. Daniel
(b) Address 210 Bloomsbury Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 3. 1948 (month) (day) (year)
(c) Cemetery or crematory Morgan Chapel
Location Woodbine-Carroll Co.

18 (a) Funeral director Wm. Mus. John McFeufel & Son
(b) Address 531 N Edmondson Ave

19 (d) FEB 2 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/31 1948 at 10:5 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed 1/31/48

G59691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G59691

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 816 N. Eutaw St
(c) Hospital or institution: 11-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 816 N. Eutaw St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rev. William A. McClenthen

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 15 1878

8. AGE: Years	Months	Days	If less than one day
70	0	16	hr. min.

9. Birthplace Camden N.J. (Town, county, and state)

10. Usual Occupation Clergyman

11. Industry or business

FATHER — 12. Name William T McClenthen

13. Birthplace —

MOTHER — 14. Maiden Name Sarah Adams

15. Birthplace —

16 (a) Informant Rev. Otto

(b) Address 816 N. Eutaw St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 3 1948 (month) (day) (year)

(c) Cemetery or crematory St Johns

Location Huntington Valley Md

18 (a) Funeral director Henry W. Jenkins Sons Co

(b) Address McCulloh & Richard Sts

19 (a) FEB 2 1948 (Date rec'd by registrar) (b) Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 Jan 1948, at 10 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 31 Jan 1948 to 1948, and that I last saw h[illegible] alive on Oct. 2 1947

Immediate cause of death	Duration
Coronary Occlusion	Sudden
Due to Coronary Sclerosis & Angina pectoris	2 years
Due to Generalized Arteriosclerosis Hypertension	—
Other Conditions Diabetes Mellitus	6 years + Dies 1931

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. Otto Hamburger Jr.

Address 1207 Eutaw Place Date signed 2/2/48

VS 150

94a

G59692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

G59692 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3401 Greenway
(c) Hospital or institution: 122
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3401 Greenway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNE COLEMAN HEBNER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife George Hebner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
About 79			hr. min.

9. Birthplace Howard County, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Patrick Coleman
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Mc Connell
15. Birthplace Ireland

16 (a) Informant Miss Marie Hebner
(b) Address 3401 Greenway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. H. Myers and Son
(b) Address 805 N. Calvert St

19 FEB 2 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1948, at 7P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 30 1947 to Jan 31 1948 and that I last saw h alive on Jan 31 1948

Immediate cause of death: Chronic Myocarditis — Duration: 1

Due to

Due to

Other Conditions Carcinoma of Cervix (Include pregnancy within 3 months of death)

Date of operation Dec. 11-1947

Major findings of operation: Carcinoma of cervix

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm J Schmidt

Address 701 N. Kenwood Ave Date signed 2/7/48

VS 150

937

G59693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G59693

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 9-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 621 E. 28th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** RAYMOND ROBINSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31, 1935

8. AGE: Years	Months	Days	If less than one day
12	9	29	hr. min.

9. Birthplace Fairview, Va (town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER 12. Name Roman O. Robinson

13. Birthplace Charlie Hope, Va

MOTHER 14. Maiden Name Edith M. Bailey

15. Birthplace Fairview, Va

16 (a) Informant Mrs. Edith M. Robinson

(b) Address 641 E. 28th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-1948 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk.

Location Balto. Co. Md.

18 (a) Funeral director Mrs. George M. Holland

(b) Address 1631 Mitchell & Hill Ave.

19 (a) FEB 2 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30, 1948, at 1.08P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured of Portal Vein
Ruptured of Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 9/4

(a) Date of injury 1-30-48 at 12.30 P.M.

(b) Where did injury occur? Reese & 30th St. Baltimore, Md.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Sleigh riding struck by auto.

23. Signature Earl C. Ryze M.D. Medical Examiner

Date signed 1-30-48

X

G59694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G59694

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Laynes & Lakeland

(c) Hospital or institution: The Baltimore General Hosp. 7-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3525 Lucille Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Grass.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Freda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation School Teacher

11. Industry or business

FATHER

12. Name Max Grass

13. Birthplace Poland

MOTHER

14. Maiden Name Unkown

15. Birthplace Poland

16 (a) Informant Mrs Freda Grass

(b) Address 3525 Lucille Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 3, 1948 (month) (day) (year)

(c) Cemetery or crematory Hebrew Rosedale

Location Hamilton Ave.

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124-1126 W North Ave

19 (a) FEB 2 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 February 1948, at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/22 1948, to 2/1 1948 and that I last saw him alive on 2/1 1948

Immediate cause of death Cardiac Failure.

Due to Coronary Occlusion + Shock.

Due to Arteriosclerosis

Other Conditions C. V. Dis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Leslie A. Hall Jr. M. D.

Address East Baltimore General Hosp. Date signed 2/1/48

VS 159

59695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 59695

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland.
(b) Street address Madison Ave & Linden Ave
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 Clifton Ave 13 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Anna F. ~~Smith~~ Schmidt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife James T. Schmidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1878

8. AGE: Years	Months	Days	If less than one day
69	9	8	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ✓ Weiners
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Mr. Harold Schmidt
(b) Address 1510 Cliftview Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 2-5-48 (month) (day) (year)
(c) Cemetery or crematory Maryland Pk.
Location Baltimore Md.

18 (a) Funeral director Leonard J Buck
(b) Address 5215 Harford Rd

19 (a) FEB 2 1948 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Feb 1948, at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 30 Jan 1948 to 1 Feb 1948, and that I last saw h[illegible] alive on 1 Feb 1948.

Immediate cause of death	Duration
Uremia	3 days
Due to Circulatory failure	1 week
Due to Coronary artery disease	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Allan Spies
Address Md. Gen. Hosp Date signed 1 Feb 48 M.D.

VS 190

G59696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G59696

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2816 Inglewood Avenue
(c) Hospital or institution: 27-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2816 Inglewood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH F. WESS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Nellie E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1889

8. AGE: Years	Months	Days	If less than one day
58	7	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Adolph Wess
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Holslein
15. Birthplace Germany

16 (a) Informant Mrs. Nellie E. Wess
(b) Address 2816 Inglewood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-4-48 (month) (day) (year)
(c) Cemetery or crematory Morelands
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) 2 1948 (Date rec'd by registrar) (b) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31st, 1948, at 8:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 1, 1947 to January 31, 1948 and that I last saw him alive on Jan. 31, 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	2 Days
Due to Cardio-Vascular Hypertensive disease	3 years
Due to Arteriosclerosis	3 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Michael J. Dowd M.D. M. D.
Address 1W. Chesley Ave. Date signed 2/3/48

V S 150

C59697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. C59697

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2237 Fulton Avenue
(c) Hospital or institution: 19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 223 N. Fulton Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** William J. McDevitt

3 (b) If veteran, name war 1st World War U.S. Army Veteran | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15th 1876

8. AGE: Years	Months	Days	If less than one day
71	5	16	hr. min.

9. Birthplace Texas. Balto. Co. Md. (Town, county, and state)
10. Usual Occupation Soldier
11. Industry or business U. S. Army (retired)

FATHER
12. Name Frank McDevitt
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Kane
15. Birthplace Ireland.

16 (a) Informant Mrs. Joseph McGee (sister)
(b) Address 223 N. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cem.
Location 5301 Frederick Ave

18 (a) Funeral director John J. Gannon & Son
(b) Address 901-03 Hollins St

19 (a) 2 1948 (Date received by registrar) (b) Wallington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31 1948, at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 27 1948 to Jan. 31 1948 and that I last saw him alive on Jan. 31 1948.

	Duration
Immediate cause of death: Coronary Occlusion	few hours
Due to: Arterio-sclerosis	5 yrs.
Due to: Cardio-sclerosis	5 yrs.
Other Conditions: Advd age.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bailey I. Baggott M. D.
Address 3812 Greenmount Ave Date signed 1/31/48

Vs 150

G59698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G59698 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 N. Bond Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER HARRIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Susan Harris

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Aug 16-1905

8. AGE: Years	Months	Days	If less than one day
42	5	15	hr. min.

9. Birthplace Southerland va (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name John Harris
13. Birthplace Southerland va

MOTHER
14. Maiden Name Lucy Jones
15. Birthplace Southerland va

16 (a) Informant Susan Harris
(b) Address 1109 N. Wolf St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 6, 1948 (month) (day) (year)
(c) Cemetery or crematory Southerland va
Location Southerland va

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly ave Huntington Williams, Md

19 (a) FEB 2 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31, 1948, at 9.20 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Congestive Edema
Acute Alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl Long M.D.
Medical Examiner.
Date signed 1-31-48

VS 151

G59699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G59699 Registered No.

CH. 117065 74a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1924 Penna. Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Parran

3 (b) If veteran, name war: WW I
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11- 1894

8. AGE: Years	Months	Days	If less than one day
53	4	20	hr. min.

9. Birthplace MD. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records B. lto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/48 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Md

18 (a) Funeral director Leo G. Kelly
(b) Address 2023 Freeman St

19 (a) FEB 2 1948 (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 -31- 1948 at 4.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1 - 30 1948 to 1-31 - 1948, and that I last saw him alive on Jan. 31 1948.

Immediate cause of death	Duration
Cerebral Thrombosis	12 hr
Due to Leukemia, Chr. Lymphatic	3 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Petechial hemorrhages, brain
of autopsy Chr. Lymph Leukemia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William M. Straight M. D.
Address Balto City Hosp Date signed 2-1-48

X

G59700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G59700 Registered No. 3698

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1300 Calhoun St.
(c) Hospital or institution: 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) over 10 years
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1300 Calhoun St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Adella Watkins
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife Perry Watkins
6 (c) If alive, give age 52 years
7. Birth date of deceased (mo., day, yr.) 1903
8. AGE: Years 44 | Months | Days | If less than one day ... hr. ... min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business own home

FATHER
12. Name Richard Jongua
13. Birthplace md

MOTHER
14. Maiden Name Bertie Harrod
15. Birthplace Md

16 (a) Informant Charley Jongua
(b) Address 300 N. Bruce St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/48 (month) (day) (year)
(c) Cemetery or crematory Gabriel's
Location Md
18 (a) Funeral director Geo. H. Nelson
(b) Address 1303 Presstman St
19 (a) FEB 2 1948 (Date rec'd by registrar) (b) Registrar
Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-31-1948, at 1 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 1-14-1948 to 1-31-1948
and that I last saw her alive on 1-30-1948

Immediate cause of death: Cerebral hemorrhage — Duration: 1 day
Due to:
Due to: Hypertension and bronchopneumonia
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker Date signed 2-2-1948

G59701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

G59701 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2212 Penna Ave.
(c) Hospital or institution: 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) No
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 Penna Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Clarence Figueroa

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Margaret Figueroa

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Dec 5, 1900

8. AGE: Years 47 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Figueroa
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Carter
15. Birthplace Md.

16 (a) Informant Elizabeth Figueroa
(b) Address 2212 Penna Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/48 (month) (day) (year)
(c) Cemetery or crematory Carlton
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Druid Hill Ave

19 (a) FEB 2 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1948, at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 1948 to Jan 30 1948 and that I last saw him alive on Jan 30 19, 48

	Duration
Immediate cause of death: Cardio Vascular Disease	1 yr
Due to: Carbuncle of Face	6 mo's
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. William Frey, M.D.
Address 1928 Penna Ave Date signed 2/2/48

X

G59702

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

G59702 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St 24-7
(c) Hospital or institution: South Balto General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 808 E. Fort Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Lewis Dolphin

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-2419

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hazel F. Dolphin (Nee Boehmer)
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) July 21, 1895

8. AGE: Years 52 | Months 6 | Days 10 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Clerk (Shipping & Receiving)
11. Industry or business Mayer's Dept. Store

FATHER
12. Name William Dolphin
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Hannah Schmidt
15. Birthplace Germany

16 (a) Informant wife - Hazel F. Dolphin
(b) Address 808 E. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mon. Feb 5 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Parklawn
Location Balto Md

18 (a) Funeral director Edward Evans
(b) Address 1400 N. Charles St.

19 (a) [illegible] (Date received by registrar) Clinton Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sun. Feb 1 1948 at 2.45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1948 to Feb 1 1948, and that I last saw him alive on Feb 1 1948.

Immediate cause of death: Coronary Insufficiency & Pulmonary Effusion — Duration: 1 month
Due to: Arteriosclerotic Heart Disease
Due to:
Other Conditions: Diabetes Mellitus; Pulmonary Tuberculosis inactive
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: above findings

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Dillon M. D.
Address South Balto Gen Hosp Date signed 2-1-48

FEB 2 1948

VS 150

937

G59703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G59703

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lake Drive near Linden Ave. Alhambra Apts.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 10 Days.

2. USUAL RESIDENCE OF DECEASED:

(a) State Pa. (b) County

(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)

(d) Street No. 6804 N. 11th. St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME BLANCHE S. WEIL.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow (Moses)

6 (b) Name of husband or wife Moe Weil.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1872

8. AGE: Years	Months	Days	If less than one day
75	6	13	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Levi Spandauer,

13. Birthplace Germany.

MOTHER 14. Maiden Name Rosa Hutzler,

15. Birthplace Germany.

16 (a) Informant Mrs. M. Reinach (Sister)

(b) Address Alhambra Apts.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2. 3. 48. (month) (day) (year)

(c) Cemetery or crematory Adath Jashurum.

Location Philadelphia, Pa.

18 (a) Funeral director Harris Levinson & Son

(b) Address 1902 Eutaw Place.

FEB 2 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1st. 1948 at A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28 1947 to Feb 1 1948 and that I last saw h[illegible] alive on Feb 1 1948

Immediate cause of death	Duration
Acute dilatation of Heart (Oedema of Lungs)	2 hrs
Due to Coronary artery disease	1 yrs
Due to Arteria. sclerosis	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature I. Frederick Lecky M. D.

Address Temple Garden Apts. Date signed 2/10/48

VS 150

G59704 ✓ G59704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1178

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1919 Eutaw Place.
(c) Hospital or institution: 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1919 Eutaw Place. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ALMA GOLDSMITH.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1868.

8. AGE: Years	Months	Days	If less than one day
79	5	20	hr. min.

9. Birthplace Bremen, Germany. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Eduoard Goldsmith,
13. Birthplace Germany.

MOTHER
14. Maiden Name Julia Frank,
15. Birthplace Germany.

16 (a) Informant Miss. Olga Goldsmith,
(b) Address 1919 Eutaw Place.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2.4.48. (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom
Location Balto. Md.

18 (a) Funeral director Sinai Memorial Chapel
(b) Address 1902 Eutaw Place.

19 (a) (Date rec'd by registrar) (b) Registered

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2nd. 1948 at 4.10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1948 to 2/1 1948. and that I last saw h[illegible] alive on 2/1 1948.

Immediate cause of death	Duration
Coronary occlusion, with Myo-Cardial infarction	3 days
Due to Coronary arteriosclerosis	10 yrs
Due to Hypertensive Heart Disease	10 yrs
Other Conditions Duodenal Ulcer (Include pregnancy within 3 months of death)	17 yrs

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sholom Rubin M.D.
Address 244 N. Hilton St. Date signed 2/4/48

FEB 2 1948

VS 150

937

G59705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G59705 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1903 Orleans St
(c) Hospital or institution: 6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1903 Orleans St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lillian Andree (Lillian E. Andree)

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frederick Andree

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1883

8. AGE: Years 64 | Months 1 | Days 6 | If less than one day hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER
12. Name: Wm. Talley
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Frances Boyce
15. Birthplace: Balto. Md.

16 (a) Informant: Frederick Andree
(b) Address: 1903 Orleans St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 4/48 (month) (day) (year)
(c) Cemetery or crematory: Schwartz's Cem.
Location: Balto. Md.

18 (a) Funeral director: Philip Hennig Sons
(b) Address: 2024 Orleans St.

19 (a) 2 Feb (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Feb, 1948 at 1:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Hypertension Cardio-Vascular Renal.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Wm. H. Kammer Jr. M.D. Medical Examiner.
Date signed 27 Feb. 1948

VS 181

G59706 ✓ G59706

BALTIMORE CITY HEALTH DEPARTMENT

BC-48-00675 CERTIFICATE OF DEATH 157B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga St.
(c) Hospital or institution: Mercy Hospital 27-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3914 Echodale Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Diane Elizabeth Cassahn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 13, 1948

8. AGE: Years | Months | Days: 19 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Luther C. Cassahn

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden Name Elizabeth Hoffmeyer

MOTHER 15. Birthplace Maryland

16 (a) Informant Father

(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 (month) 7 (day) 48 (year)

(c) Cemetery or crematory Greenmount

Location Balto. Md.

18 (a) Funeral director Cassahn Funeral Home

(b) Address 7401 Belair Rd.

19 (a) FEB 2 1948 (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1 1948, at 5 20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1948 to Feb 1 1948 and that I last saw her alive on Feb 1 1948.

Immediate cause of death: Cardio-respiratory failure

Due to Spina Bifida

Due to Meningomyelocele

Other Conditions Meningitis?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clarence E. McWilliams M. D.

Address Mercy Hospital Date signed 2-1-48

X

G59707

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

G59707
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1508 N. Luzerne Avenue
(c) Hospital or institution: 8-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 N. Luzerne Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN BARBARA OPAROWSKI

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife James
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) December 15, 1898

8. AGE: Years 49 | Months 1 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Teofil Skalinski
13. Birthplace Poland

MOTHER
14. Maiden Name Jozefa Szamska
15. Birthplace Poland

16 (a) Informant Mr. James Oparowski
(b) Address 1508 N. Luzerne Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/48 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. F. Sadowski & Sons
(b) Address 1808 Eastern Avenue

19 (a) [illegible] (b) [illegible]
(Date received by registrar) Registrar

FEB 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 48, at 10 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1948 to Jan 30 1948, and that I last saw her alive on Jan 30 1948.

	Duration
Immediate cause of death: Coronary Thrombosis	1/30/48
Due to: Chr. Myocarditis	3/1945
Due to: Diabetes Mellitus	1/10/44
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Rosario M. D.
Address 801 W Lexington St Date signed 2/4/48

VS 150

G59708 ✓ G59708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45c

Registered No.

GM. 117040

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 8-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1682 Darley Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph DeKowski (Dekowski)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Julia
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Feb. 16 -1902

8. AGE: Years	Months	Days	If less than one day
45	11	13	hr. min.

9. Birthplace MD. (Baltimore) (Town, county, and state)
10. Usual Occupation Steelworker
11. Industry or business General Contractors

FATHER
12. Name Record Balto. City Hospitals John DeKowski
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Pumlewska
15. Birthplace Poland

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/48 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. F. Sadowski & Sons
(b) Address 1808 Eastern Avenue

19 (a) (Date received by registrar) (b) Registrar

FEB 6 1948 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 1 - 1948, 5.08 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1 - 29 - 1948, to 2 - 1 - 1948, and that I last saw him alive on 2 - 1 - 1948.

Immediate cause of death	Duration
Carcinoma of Floor of mouth Metastases	
Due to Hypertension - Cardiovasc. Disease	
Due to	
Due to	
Other Conditions Malnutrition	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Frank L. Tarasco
Address Baltimore City Hosp Date signed M. D. 2/1/48

X

G59709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59709

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1506 Boyle St
(c) Hospital or institution: 7-4-L
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 Boyle (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emil Heinrich Wilhelm Linke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Louisa H Linke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 22 1880

8. AGE: Years	Months	Days	If less than one day
67	3	8	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Paper Board Co

FATHER
12. Name Anton Linke
13. Birthplace Germany

MOTHER
14. Maiden Name Anna ?
15. Birthplace Germany

16 (a) Informant Mrs Louisa Linke
(b) Address 1506 Boyle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 2 1948 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Co Md

18 (a) Funeral director Wilbank Funeral Home
(b) Address 2008 Orleans St

19 (a) FEB 2 1948 (Date received by Registrar) (b) Huntington Williamsport, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-30 1948 at 2.20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1 1947 to 1-30 1948 and that I last saw him alive on 1-30 1948

Immediate cause of death Cerebral Hemorrhage — Duration 1 Day
Due to Arteriosclerosis — 1 Yr.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Sallod

Address 707 Fort Ave. Date signed 1-30-48 M. D.

G59710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

G59710 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 845 S. Oldham Street.
(c) Hospital or institution: 26-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 845 S. Oldham Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN SHAW

3 (b) If veteran, name war 6

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Florence Shaw

6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) August 9 th 1912

8. AGE: Years 35 | Months 5 | Days 22 | If less than one day: hr. min.

9. Birthplace: Hot Springs Va
(Town, county, and state)

10. Usual Occupation: Burner Ship Yard

11. Industry or business

FATHER
12. Name: Fra nk W. Shaw
13. Birthplace: Va.

MOTHER
14. Maiden Name: Ethel M. Smith
15. Birthplace: Va.

16 (a) Informant: Florence Shaw
(b) Address: 825 S. Oldham St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 3 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location City

18 (a) Funeral director Leeder Funeral Home
(b) Address 2005 Orleans St

19 (a) (Date received by registrar) Huntington Williams M.D.

FEB 2 1948

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31, 1948, at 2.40 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 24/2

(a) Date of injury 1-31-48 at about 2 a.m.
(b) Where did injury occur? Pier #5, Beth. Ship-building 1101 Key Highway Balto.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury. Fell over-board.

23. Signature Earl [illegible] M.D.
Medical Examiner.

Date signed 1-31-48

G59711 SENARVITIS Senarvitis G59711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution: Home for the Aged Poor 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Senarvitis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Ac Senarvitis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Lithuania
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Peter Laposkas

13. Birthplace

MOTHER 14. Maiden Name Agnes Karchankas

15. Birthplace

16 (a) Informant Sister-in-law Tax Poor

(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 3, 1948 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore

18 (a) Funeral director Rita Wiedefeld

(b) Address 900 E Biddle St

19 (a) FEB 2 1948 (Date received by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31 1948, at about 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 1948, to Jan 31 1948, and that I last saw her alive on Jan 31 1948.

	Duration
Immediate cause of death: Acute Dilatation Heart	1 day
Due to: Mitral Stenosis	5 yrs
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.

Address 1631 E North Av Date signed 2/1/48

X

G59712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 182B

G59712 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Ave.
(c) Hospital or institution: Ardleigh Nursing Home 9-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 601 E. 28th St.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** Nannie G. Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Charles R. Martin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years	Months	Days	If less than one day
82			hr. min.

9. Birthplace Frederick, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Lewis Mowbray
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name
15. Birthplace Frederick, Md.

16 (a) Informant Charles Richard Martin, Jr.
(b) Address Homewood Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/48 (month) (day) (year)
(c) Cemetery ~~crematory~~ Mt. Olivet
Location Frederick, Md.

18 (a) Funeral director John O. Mitchell & Son, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date received by registrar) (b) Washington Funeral Directors

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1948 to Feb 1 1948 and that I last saw h alive on Jan 31 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 Days
Due to Arterio Sclerosis	6 mos
Due to Cerebral Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. E. Hoff M.D.
Address 2020 N. Charles St. Date signed 2/4/48

Dr. Geo. E. Hoff

G59713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

G59713 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3912 Norfolk Ave.
(c) Hospital or institution: none 15-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3912 Norfolk Ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Anna May Ritter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Wade H. Ritter
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1880

8. AGE: Years	Months	Days	If less than one day
67	11	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name ? Dominick
13. Birthplace ?

MOTHER
14. Maiden Name Mathilda Taunte Dominick
15. Birthplace Frankfort on The Mein, Germany

16 (a) Informant Wade H. Ritter
(b) Address 3912 Norfolk Ave.

17 (a) Burial (b) Date thereof 2/3/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Loudon Park
Location 3801 Frederick Ave., Baltimore

18 (a) Funeral director Asher O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31 1948 at 4.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/31/48 19 to 1/31/48 19
and that I last saw him alive on 1/31/48 19

Immediate cause of death Myocarditis acute — Duration years

Due to Cardiac failure

Due to Old age

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 4012 Edmondson Ave. Date signed

VS 150

Dr. Walter X Sowers 2-3

G59714

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

G59714
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3812 Bonner Rd.
(c) Hospital or institution: 59
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3812 Bonner Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA M. HOBBS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Walter K. Hobbs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1873

8. AGE: Years 74 | Months 5 | Days 11 | If less than one day ... hr. ... min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John C. Hartzell
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary P. Pfeister
15 Birthplace Balto., Md.

16 (a) Informant Mrs. Helen T. Seddicum
(b) Address 3812 Bonner Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) (b) Registrar
FEB 2 1948
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1, 1948, at 9:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1946 to Feb 1 1948, and that I last saw h.cn alive on Jan 24 1948

Immediate cause of death Coronary Occlusion — Duration 30 mn

Due to Hypertensive Cardio-vascular Renal disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. McAleer M. D.
Address 3321 Frederick Ave Date signed 2/2/48

VS 159

X 2/2/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G59715
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 W. Rogers Ave.
(c) Hospital or institution: Methodist Home Foe the Aged 27-15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 W. Rogers Ave (If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME MARIE A. HOHMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
***	-----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife John C. Hohman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1863

8. AGE: Years	Months	Days	If less than one day
84	1	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation ---
11. Industry or business ---

FATHER
12. Name John Geo. Kilkian
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Danerman
15. Birthplace Germany

16 (a) Informant Mrs. Mamie Fisher
(b) Address 2211 W. Rogers Ave.--Ass't Supt.

17 (a) Bueial (Burial, cremation, or removal) (b) Date thereof 2/3/48 (month) (day) (year)
(c) Cemetery or ~~xxxxxx~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves, Baltimore, Md.

19 (a) FEB 2 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31, 1948 19 , at 3:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1947 to JAN 30 1948 and that I last saw he alive on JAN. 30 1948.

Immediate cause of death	Duration
Myocarditis	10 days
Due to Arteriosclerosis	20 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur J. Davis M. D.
Address 800 N 3rd Date signed 2-2-48

VS 150

G59716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G59716

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4017 Frederick Ave.
(c) Hospital or institution: 70-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4017 Frederick Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur G. Decker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1896.

8. AGE: Years	Months	Days	If less than one day
51	4	18	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Milton B. Decker
13. Birthplace Pa.

MOTHER
14. Maiden Name Georgia A. Black
15. Birthplace Md.

16 (a) Informant Mrs. Margaret H. Reimers
(b) Address 3911 Edmondson Ave.

17 (a) Burial (b) Date thereof Feb. 3/48.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location 2930 Frederick Rd.

18 (a) Funeral director Harry A. Lutz Sr.
(b) Address 4101 Edmondson Ave.

19 FEB 3 1948 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31/48. 19 at 5-P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/24/48 19 to 1/30/48 19, and that I last saw h. alive on 1/30/48 19

Immediate cause of death	Duration
Pulmonary Embolism	Hours
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter F. Corbin

Address 4015 Edmondson Ave. Date signed 2/3/48

VS 150

G59717 BC: C 98131 G59717

BALTIMORE CITY HEALTH DEPARTMENT Registered No.

CERTIFICATE OF DEATH ✓159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1933 N. Lombard St. 20-3
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: 20-3
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1933 N. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME — — Morgan

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10/31/[illegible]
8. AGE: Years — Months — Days — If less than one day hr. 30 min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Griffith Morgan
13. Birthplace Easton Pa
14. Maiden Name Charlotte Gertrude Lipsky
15. Birthplace Nikkatowe Pa

16 (a) Informant Griffith Morgan
(b) Address 1933 N. Lombard St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 22/47 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.
18 (a) Funeral director George L. Schmidt
(b) Address 2101 Eutaw Pl.
19 DEC 26 1947 (Date received by Registrar) (By) Huntington Williams, M.D. Registrar

FEB 18 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21 1947, at 8 57 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21 1947, to Dec 21 1947 and that I last saw him alive on Dec 21 1947.

Immediate cause of death — Duration

Undetermined — 30 Min.

Due to

Due to

Other Conditions Prematurity —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Earl Pass M. D.
Address 4001 W. Chesapeake Date signed 12-22-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G59718 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SPACES RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens
(c) Hospital or institution: St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County W. S. O.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 603 Brinsondale
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDGAR WILLIAM BUCKLEY

3 (b) If veteran, name war None | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Margaret Foley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 19, 1887

8. AGE: Years	Months	Days	If less than one day hr.	min.
58	5	12		

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Structural Iron Worker
11. Industry or business

FATHER
12. Name Mr. Edgar W. Buckley
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Foley
15. Birthplace Baltimore Md

16 (a) Informant Thelma A Buckley
(b) Address 935 Brunswick St
17. Burial (Burial, cremation, or removal) (b) Date thereof 2/16/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md
18 (a) Funeral director Tilghman & Son
(b) Address 1219 Park Ave
19 (a) FEB 3 1948 (Date rec'd by Registrar) (b) Washington Hill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 February 1948 at 9:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 30 Jan 1948 to 17 Feb 1948 and that I last saw him alive on 17 Feb 1948

Immediate cause of death Respiratory Failure — Duration
Due to Cerebro Vascular Accident
Due to Hypertensive C-V Disease Advanced Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature James E Hamilton M.D.
Address St Agnes Hosp. Date signed 17 Feb 48

VS 150

G59719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G59719

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PERSONS ASSISTED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Ave 27-15
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4306 Falls Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nannie L. Klueber

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John H. Klueber

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 22-1885

8. AGE: Years 62 | Months 3 4 | Days 10 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Robert Reeves

13. Birthplace Md.

MOTHER 14. Maiden Name Margaret Callahan

15. Birthplace Md.

16 (a) Informant John H. Klueber

(b) Address 4306 Falls Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore

18 (a) Funeral director Philip Hergus Sons

(b) Address 1024 Orleans St.

19 (a) FEB 2 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1 1948, at 3- P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1948 to Feb 1 1948, and that I last saw her alive on Feb 1 1948.

	Duration
Immediate cause of death: PNEUMONIA	3 DAYS.
Due to CEREBRAL HEMORRHAGE	1 MO.
Due to ARTERIOSCLEROSIS DIABETES MELLITUS	3 YRS 3 YRS.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James F. Hannaugh M.D.

Address 3614 W. Cold Spring Ln. Date signed 2-2-48 M. D.

V S 150

X

G59720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G59720 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division
(c) Hospital or institution: Provident 16-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1437 W. Lenvale (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME William Dobbs

3 (b) If veteran, name war No

3 (c) Social Security Account No. 213-03-2171

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-9-1880

8. AGE: Years	Months	Days	If less than one day
67	9	21	hr. min.

9. Birthplace Blackstone Va (Town, county, and state)

10. Usual Occupation Construction work

11. Industry or business

FATHER 12. Name George Dobbs
13. Birthplace Va.

MOTHER 14. Maiden Name —
15. Birthplace —

16 (a) Informant George Dobbs (S)
(b) Address 512 Davis St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-3-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore

18 (a) Funeral director Chas H. Gorter
(b) Address 512 Carrollton Ave

FEB (a) 3 1948 (Date rec'd by registrar) at Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/30 1948, at 12 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/19 1948 to 1/30 1948, and that I last saw him alive on 1/30 1948.

Immediate cause of death Myocardial Failure — Duration

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. Preston Stuart

Address 1514 Division Ave Date signed 2/2/48 M.D.

VS 150

G59721

AB-117002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. G59721

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1804 N. Durham St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Blanche Powell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Bruce Powell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 13-1885

8. AGE: Years 61 | Months 10 | Days 19 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER

12. Name Ormsby Webster Shinnick

13. Birthplace Md.

MOTHER

14. Maiden Name Martha Estridge

15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/48 (month) (day) (year)

(c) Cemetery or crematory Meadow Ridge

Location Washington Blvd.

18 (a) Funeral director Clarence F. Hoffmann

(b) Address 1639 Broadway

19 FEB 3 1948 Huntington Williams, M.D. (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1- 1948, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-28- 1948, to 2-1- 1948 and that I last saw her alive on 2-1- 1948.

Immediate cause of death	Duration
1) Cardiac Failure	5 da
2) Pneumonia	3 da
Due to Rheumatic heart Disease & mitral stenosis	3
Due to and Auricular Fibrillation	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: R Lt. D. & mitral stenosis

of autopsy: pneumonia

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W.M. Straight M. D.

Address Balto City Hosp Date signed 2-1-48

VS 150

G59722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G59722
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 809 N. Streeper St.
(c) Hospital or institution: 7-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 809 N. Streeper St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oliver J. Peacher Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Balbina Stachowska
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1892

8. AGE: Years	Months	Days	If less than one day
55	8	20	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Bakery

11. Industry or business

FATHER
12. Name Oliver J. Peacher
13. Birthplace Harpers Ferry, Wa.Va.

MOTHER
14. Maiden Name Dora A. Crouch
15. Birthplace Kent Co., Md.

16 (a) Informant Wife
(b) Address 809 N. Streeper St.

17 (a) Burial (b) Date thereof 2/3/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) FEB 3 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1947 to Jan 30 1948
and that I last saw h alive on 19

Immediate cause of death — Coronary Occlusion — Duration 1/30/48
Due to Chr Myocarditis — 3 yrs
Due to Diabetes Mellitus — 3 yrs
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Peacher M. D.
Address 8014 Kenwood Ave Date signed 2/2/48

VS 150

659723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

659723 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 17-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 833 W. Franklin Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME AGNES HUGGINS ~ Higgins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife Daniel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 29 1901

8. AGE: Years	Months	Days	If less than one day
46 47	9	1	hr. min.

9. Birthplace Frederick, Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name James Duffin
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Margaret Woolford
(b) Address 644 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2? 3 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Joseph L. Russ
(b) Address 1200 McCulloh St.

19 (a) FEB 8 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 1948, at 9:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Contusion of brain.
Subarachnoid hemorrhage.
Due to Laceration of scalp.
Atelectasis of left lower lung
Other Conditions Syphilitic aortitis.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 15/4
(a) Date of injury 1-22-48 at 7:10 P M.
(b) Where did injury occur? North Ave & Ruxton Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian--Hit and Run

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 1/31/48

G59724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1931

Registered No. G59724

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1608 Ashburton St.,
(c) Hospital or institution: 15-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 74-1-19

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 Ashburton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Henry Glendenning, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Florence B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22, 1873

8. AGE: Years	Months	Days	If less than one day
74	1	10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Maintenanace Man
11. Industry or business Muskin Shoe Co.

FATHER
12. Name William Glendenning
13. Birthplace England

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Mrs. Mary R. Hughes
(b) Address 1608 Ashburton St.,

17 (a) Burial (b) Date thereof 2-4-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director J. Howard Strong
(b) Address 5207 W. North Ave.,

19 (a) 2-3 1948 Huntington Williams, M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1, 1948, at 1.10 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1942 to Feb. 1 1948 and that I last saw him alive on Jan. 31 1948.

Immediate cause of death	Duration
Arteriosclerosis	5Yrd
Due to Chronic Myocarditis	5yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Williams M. D.
Address 737 W Mont Date signed 2/3/48

VS 150

X

G59725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G59725 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Monument Sts.
(c) Hospital or institution: Johns Hopkins Hospital 3-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 Stiles Street.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country — — —

3 (a) FULL NAME WILLIAM HELLMERS

3 (b) If veteran, name war — — —

3 (c) Social Security Account No. — — —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	SINGLE

6 (b) Name of husband or wife NONE

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1-15-1855

8. AGE: Years	Months	Days	If less than one day
93	0	15	hr. min.

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation CIGAR MAKER

11. Industry or business CIGARS

FATHER
12. Name HENRY HELLMERS
13. Birthplace ?

MOTHER
14. Maiden Name FANNY ?
15. Birthplace ?

16 (a) Informant CRISTIAN HELLMERS
(b) Address 2909 McELDERRY St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-4-48 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE. EXT.

18 (a) Funeral director LILLY & ZEILER INC.
(b) Address 403 S. WOLFE ST.

19 FEB 3 1948 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1, 1948, at 3.20 P.M.

21. I certify that I took charge of the remains described above, held an insp.& inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 2-2-48

VS 151

X

G59726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G59726 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 922 S. Conkling St.
(c) Hospital or institution: — — None — — No
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County — — —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 922 S. Conkling St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country — — — —

3 (a) FULL NAME Emma L. Crusse

3 (b) If veteran, name war — — — —
3 (c) Social Security Account No. — — — —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Henry Crusse
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Apr. 8, 1878

8. AGE: Years 69 | Months 9 | Days 24 | If less than one day: — hr. — min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name ? Gertner
13. Birthplace ?

MOTHER
14. Maiden Name Sophia ?
15 Birthplace ?

16 (a) Informant Henry Crusse
(b) Address 922 S. Conkling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-5-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. Dolfe St.

19 (a) 2 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1 1948, at 1:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1/46 19— to Feb 1-48 and that I last saw her alive on 1/1/48 19—.

	Duration
Immediate cause of death: Coronary Embolism	5 mos
Due to: Arteriosclerosis	10 yrs.
Due to:	
Other Conditions: R. Hemiplegia	3 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. M. Herrman
Address 1710 E. 33rd St. Date signed 2/2/48 M.D.

VS 150

G59727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59727

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3721 Roland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3721 Roland Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Richard Hebb

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-10-0426

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Daisy L. Hebb

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5 1876

8. AGE: Years 71 Months 6 Days 26 If less than one day hr. min.

9. Birthplace St. Mary's Co. Maryland (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Black & Decker

FATHER
12. Name Griffith Hebb
13. Birthplace Maryland

MOTHER
14. Maiden Name Betty Ejulia —
15. Birthplace Maryland

16 (a) Informant Mrs. Daisy L. Hebb
(b) Address 3721 Roland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 4-1948 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Mem. Park
Location Howard Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 FEB 3 1948 (Date received by Registrar) (Signature) Stinton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1- 1948 at 5 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1947 to 2/1 1948, and that I last saw h[illegible] alive on 2/1 1948.

Immediate cause of death Cerebral Thrumb. — Duration 6 days

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Daisy L. Hebb

Address 2020 4. Charles Date signed 2/2/48 M.D.

vs fso

G59728 Oh signed by medical Examiner office

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G59728

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Madison & Linden Ave.

(c) Hospital or institution: Maryland Gen. Hospital 27-15

(d) Length of stay in hospital or inst. (~~yrs.~~ ~~mos.~~, or days) 41

(e) Length of stay in Baltimore (yrs., mos., or days) APPR. 55 YR

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2211 Rogers Ave (If rural give location)

(e) Citizen of foreign country? (~~Witness~~ or No) If yes, name country

3 (a) **FULL NAME** Miss Ida Childs

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 21, 1862

8. AGE: Years 85 | Months 6 | Days 10 | If less than one day ... hr. ... min.

9. Birthplace ANNE ARUNDEL Co. MD. (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business —

FATHER

12. Name JOSEPH HENRY CHILDS

13. Birthplace MARYLAND

MOTHER

14. Maiden Name MARY OWENS

15. Birthplace MARYLAND

16 (a) Informant MIRIAM O. COATES - Supt.

(b) Address 2211 W. ROGERS AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/5/48 (month) (day) (year)

(c) Cemetery or crematory MT. OLIVET

Location BALTIMORE, MD

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address BALTO. MD.

19 (a) FEB 3 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Feb. 1948, at 10 a. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 20 Dec. 1947 to 1 Feb. 1948 and that I last saw her alive on 1 Feb. 1948

Immediate cause of death	Duration
Cardiac decompensation	
Due to Chr. myocarditis	
Due to arteriosclerosis	
Other Conditions Chr. hypertrophy fracture rt. hip (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27/15

(a) Accident, ~~suicide or homicide~~

(b) Date of occurrence 19 Dec. 1947 at M

(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home for aged While at ~~work~~ (Specify type of place)

(e) Means of injury Pt. fell to floor

23. Signature M. T. McLogan M. D.

Address Md Gen Hospital Date signed 2 Feb 48

In ~~case~~ of ~~death~~ ~~certified~~ by Howard J. Mencis, M. D. X

VS 150

G59729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G59729 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1818 N. Fulton Ave.
(c) Hospital or institution: --
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) --

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? -- (Yes or No) If yes, name country --

3 (a) FULL NAME JACOB FREEDENBURG

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NO

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife: Catherine Freedenburg Nee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 29, 1870

8. AGE: Years	Months	Days	If less than one day
78	0	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Geo. Freedenburg
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary C. Long
15. Birthplace Germany

16 (a) Informant Miss Viola Freedenburg
(b) Address 1818 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/48 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Loudon Park
Location Baltimore, Md.

18 (a) Funeral director W. J. TICKNER & SONS
(b) Address North & Pa. Aves; Balto., Md.

19 (a) FEB 2 1948 (Date rec'd by Registrar) (b) Huntington Williams (Registrar)

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31, 1948, at a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1945 to Jan 31 1948. and that I last saw h alive on Jan 31 1948.

Immediate cause of death	Duration
Cancer of Intestines	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A Evans M. D.
Address 612 W 40th St Date signed 2-2-48

X

G59730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G59730 Registered No. h

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 422 Evesham Ave
(c) Hospital or institution: 27-17
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 422 Evesham Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Augusta S. Siemers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband ~~or wife~~ George H. Siemers
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
68	-	-	hr. min.

9. Birthplace Baltimore Md. (Town, county, and State)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Geo. Bartholomaei
13. Birthplace Balto. Md. Stockton

MOTHER
14. Maiden Name Augusta (illegible)
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Howard F. Merlish
(b) Address 422 Evesham Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-4-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Balto. Md.

18 (a) Funeral director Wm. J. Tickner & Son
(b) Address Balto., Md.

1948 FEB 2 (Date rec'd by registrar) (Huntington Woods) Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 1948, at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 25 1946 to Feb 1 1948, and that I last saw her alive on Feb 1 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	12 hrs.
Due to Arterial Hypertension	2 yrs
Due to	
Other Conditions Diabetes Mellitus	2 yrs

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature Frederick J. Valkner M. D.
Address 6100 York Road Date signed 2-1-48

VS 180

53a

G59731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G59731

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 715 Mosher Street
(c) Hospital or institution: 16-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 715 Mosher Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BENJAMIN N. WILKINS

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	yes

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1880

8. AGE: Years	Months	Days	If less than one day
67	4	9	hr. min.

9. Birthplace Chestertown Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Benjamin N. Wilkins
13. Birthplace Chestertown, Md

MOTHER
14. Maiden Name Rebecca P. Gray
15. Birthplace Chestertown, Md.

16 (a) Informant Mrs. W. L. Burdette
(b) Address

17 (a) Burial (b) Date thereof 2/4/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Chestertown Cem
Location Chestertown, Md.

18 (a) Funeral director Wm. J. Tickner & Son
(b) Address Balto. Md

19 (a) FEB 3 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/2/48 19 , at 9:00 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 2/3/48

059732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

059732 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd Sts. Baltimore MD
(c) Hospital or institution: Union Memorial Hosp. G-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2251 Cecil Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joel Jones Moore

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
no	717-07-7947	Male	W	WIDOWED

6 (b) Name of husband or wife Hitchcock
6 (c) If alive, give age - - years

7. Birth date of deceased (mo., day, yr.) Sept. 22 1874

8. AGE: Years	Months	Days	If less than one day
73	4	9	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Edward Moore
13. Birthplace Penna

MOTHER
14. Maiden Name Anna Hallman
15. Birthplace Maryland

16 (a) Informant Miss Ethel L. Moore
(b) Address 2251 Cecil Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Wm. J. Tilker & Sons
(b) Address Baltimore, Md.

19 FEB 3 1948 Huntington Williams, M.D. Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1 1948 at 6 : PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/31 1948 to 2/1 1948 and that I last saw h[illegible] alive on 2/1/48

Immediate cause of death Coronary thrombosis

Due to Arteriosclerosis

Due to

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F. Hogan Jr. M.D.
Address Union Mem. Hosp. Date signed 2/4/48

VS 150

94a

G59733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124B

G59733
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1713 Light St
(c) Hospital or institution: South Balto Gen Hosp 8-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 15 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1215 Rutland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H Glover

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 216-01-6474

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife: Jeannette Louise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8 | 21 | 1894

8. AGE: Years	Months	Days	If less than one day
53	5	11	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Gas Station Operator
11. Industry or business

FATHER
12. Name William Frederick Glover
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Krause
15. Birthplace Maryland

16 (a) Informant Miss Jeannette L. Glover
(b) Address 1215 Rutland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Balto. Md.

18 (a) Funeral director Wm. J. Fickus & Son
(b) Address Balto. Md.

19 (a) FEB 3 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 1948, at 1 PM M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28 1948 to Feb 2 1948, and that I last saw him alive on Feb 2 1948.

Immediate cause of death	Duration
Cirrhosis of the Liver	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.
Address South Balto Gen Hospital signed 2-2-48

G59734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 92c

G59734 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4021 Bateman Ave.
(c) Hospital or institution: 15-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4021 Bateman Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCIS B. H. WHITE

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
no	215-05-3474	male	white	married

6 (b) Name of husband or wife Florence W. White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 29, 1882

8. AGE: Years	Months	Days	If less than one day
65	3	2	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation American Automobile Ass'n.
11. Industry or business

FATHER
12. Name Cyrus B. White
13. Birthplace Va.

MOTHER
14. Maiden Name Frances A. Hoadley
15. Birthplace Unknown

16 (a) Informant Mrs. Florence W. White
(b) Address 4021 Bateman Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received by Registrar FEB 3 1948 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31, 1948, at 8 15 p M

21. I certify that death occurred on the date above stated; that I attended deceased from October 25 1947 to Jan. 31 1948, and that I last saw him alive on Jan 30 1948.

Immediate cause of death	Duration
Pulmonary embolus massive	
Due to Thrombophlebitis, femoral, bilateral	
Due to	
Other Conditions Rheumatic & Asteriosclerotic Heart Disease, inactive, Mitral Stenosis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry W. D. Hoffges M. D.
Address 2839 Walbrook Ave. Date signed 2-2-48

V3-150

100 13

G59735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 114E

G59735 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 3-1
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 So Bethel St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Wormley

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex Male | **5. Color or race** Colored | **6 (a) Single, married, widowed, or divorced** Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-18-99

8. AGE: Years 48 | Months 3 | Days 12 | If less than one day ___ hr. ___ min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Richard Wormley
13. Birthplace Va.

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 2-5-48 (month) (day) (year)
(c) Cemetery or crematory
Location Mt. Auburn

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna Ave

19 (Date rec'd by Registrar) 2 1948 Interim for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-30-1948, at 8:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-29-1948, to 1-30-1948, and that I last saw h[illegible] alive on 1-30-1948.

Immediate cause of death	Duration
CARDIAC FAILURE	
Due to COR PULMONALE	
Due to PULMONARY FIBROSIS & EMPHYSEMA	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Toby Hopkins

Address Johns Hopkins Hosp. Date signed 2-4-48

VS 150

G59736

HL-116922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G59736

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2000 McCulloh St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Bowen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	Married

6 (b) Name of husband or wife Mary Bowen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1897

8. AGE: Years	Months	Days	If less than one day
50	9	17	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Richard Bowen
13. Birthplace Md.

MOTHER
14. Maiden Name Daisy Boston
15. Birthplace Md.

16 (a) Informant Records Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-5-1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Wm. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 FEB 3 1948 Wellington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1 1948, at 3-45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-26 1948, to 2-1- 1948 and that I last saw him alive on 2-1 1948

Immediate cause of death	Duration
Anemia	2
Due to: Acute Lymphosarcoma (Probably)	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William M. Stanglet M. D.
Address Balto City Hosp Date signed 2-1-48

VS 150

X

G59737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59737

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1938 W. Lafayette Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1938 W. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: WILLIAM GRANT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife: Nannie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/25/1868

8. AGE: Years	Months	Days	If less than one day
79	10	6	hr. min.

9. Birthplace Onancock, Virginia (Town, county, and state)
10. Usual Occupation Insurance agent
11. Industry or business

MOTHER / FATHER
12. Name Ernest Grant
13. Birthplace Virginia
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Selma Whyte
(b) Address 1938 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Maryland.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Drudi Hill Ave.

19 (a) FEB 3 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1948, at 6A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1947 to Jan 31 1948 and that I last saw him alive on Jan 30 1948.

Immediate cause of death: Chronic Nephritis — Duration: 3 mos
Due to: Uremic Toxemia
Due to: Hypertrophy of Prostate
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation: none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph J. Young, M.D.
Address 1424 E. Monument St. Date signed 2/1/48

659738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BALTIMORE 131a

659738 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1720 McCulloh
(c) Hospital or institution: 14-V

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1720 McCulloh (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Ballenson

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-8948

4. Sex Male

5. Color or race colored

6 (a) Single, married, widowed, or divorced. ~~Married~~

6 (b) Name of husband or wife Lillie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 9 1884

8. AGE: Years 63 Months 9 Days 21 If less than one day hr. min.

9. Birthplace Cambridge, Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

MOTHER / FATHER

12. Name Unknown

13. Birthplace

MOTHER

14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mrs Jessie Vann

(b) Address 2413 N Howard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-3-1948 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Hulland

(b) Address 4631 Dunbar Hill Ave.

19 (a) FEB 3 1948 (Date rec'd by Registrar) (b) Registered by Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1948 at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1947 to Jan 31 1948 and that I last saw h[illegible] alive on Jan 30 1948

Immediate cause of death — Duration

Cardio-nephritis — 3 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Edward Fisher M. D.

Address 1642 E Monument Date Jan 31 48

G59739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59739

92c Brown

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2435 MCulloh Street
(c) Hospital or institution:

13-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2435 McCulloh Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM CATO ANDERSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Bertha B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 5, 1890

8. AGE: Years	Months	Days	If less than one day
57	5	26	hr. min.

9. Birthplace Baltimore, Maryland.
(Town, county, and state)

10. Usual Occupation Educator

11. Industry or business

FATHER
12. Name Robert Anderson
13. Birthplace Baltimore, Maryland.

MOTHER
14. Maiden Name Mary Day
15. Birthplace Baltimore, Maryland.

16 (a) Informant Bertha B. Anderson
(b) Address 2435 McCulloh Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-4-1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Baltimore Co. Maryland.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 FEB 3 1948 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-31-48 19 at 3:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-23 1946 to 1-31 1948 and that I last saw him alive on 1-22 1948

Immediate cause of death	Duration
Coronary occlusion	immediate
Due to aortic-mitral insufficiency (post-rheumatic)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rayner Browne M. D.
Address 1307 E. Madison St. Date signed 2-3-48

VS 150

Rayner Browne X

G59740
ff 116945

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G59740
Registered No. 131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 S. Ellwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Danaher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ~~1866~~ ? 1867

8. AGE: Years	Months	Days	If less than one day
78 ~~82?~~	8?	24?	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Daniel ? Danaher
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Quinn
15. Birthplace Ireland

16 (a) Informant Records Baltimore City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-4-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director John G. Moran
(b) Address 3800 E. Balt. St

19 (a) (Date received by registrar) (b) Registrar Huntington Williams, M.D.

FEB 3 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 1948, at 5:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from January 27 1948 to Feb. 1 1948, and that I last saw him alive on Feb. 1 1948.

Immediate cause of death	Duration
Arteriosclerotic Cardio-vascular Disease	
Due to	
Due to	
Other Conditions Pulmonary Edema ~~Hemorrhage~~ from Prostatic Hypertrophy	

(Include pregnancy within 3 months of death)

Date of operation 1-30-48

Major findings of operation: Above

of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marvin M. Lacy, M.D.
M.D.
Address Balt. City Hosp. Date signed 2-2-48

93D

G59741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G59741 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1328 McCulloh St.
(c) Hospital or institution: 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and the town)
(d) Street No. 1328 McCulloh St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Emma Mason

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Grant Mason

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 10, 1880

8. AGE: Years 67 | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace Smithfield, Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name ?

13. Birthplace ?

MOTHER 14. Maiden Name Charlotte Drew

15. Birthplace Va

16 (a) Informant Mrs Emily Myers

(b) Address 1328 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 6, 1948 (month) (day) (year)

(c) Cemetery or crematory

Location Hughes, Virginia

18 (a) Funeral director Charles R Law

(b) Address 802 Madison Ave

FEB 2 1948 (a) (b) Registrar

(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 1948 to Feb 1 1948 and that I last saw her alive on Feb 1 1948

Immediate cause of death

Cardio Vascular Renal Disease

Due to

Due to

Other Conditions Stanton (Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

Duration
?
1

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. C. Stanton M. D.

Address 1443 Druid Hill Ave Date signed Feb 2-48

G59742

JL - 112018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G59742

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave. 7-5

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos.

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1637 E. Monument St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edmond Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1910

8. AGE: Years	Months	Days	If less than one day
37	1	20	hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Sherman

13. Birthplace N. C.

MOTHER

14. Maiden Name Elizabeth

15. Birthplace N. C.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 4 1948 (month) (day) (year)

(c) Cemetery or crematory Balt. National Cem.

Location

18 (a) Funeral director Mrs Cott & Ellis Daughter

(b) Address 1129 N Courtland St

19 (a) FEB 2 1948 (Date rec'd by registrar) (b) Livingston Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30 1948, at 6.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1947 to Jan. 30 1948, and that I last saw him alive on Jan. 30 1948.

Immediate cause of death	Duration
Tuberculosis Pulmonary & Cavitation	
Due to	
Due to	
Other Conditions (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy: Pulmonary tbc

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William M. Straught M. D.

Address Balto City Hosp. Date signed 2-3-48

G59743
HL. 117023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G59743

Registered No. 12 1a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 11-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 727 N. Eutaw St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Payne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	Sep.

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1884

8. AGE: Years	Months	Days	If less than one day
63	7	16	hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lawrence Payne
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-4-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Balto. County Md.

18 (a) Funeral director Wm. H. Elliott Jr.
(b) Address 429 N. Charles St

(a) 2 FEB 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1 1948, at 12-20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-29 1948 to 2-1 1948, and that I last saw him alive on 2-1 1948.

Immediate cause of death	Duration
Uremia	?
Due to Arteriolar Nephrosclerosis (Probable)	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Straight M. D.
Address Balto City Hosp Date signed

VS 150

X

G59744

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

Registered No. G59744

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 S. Caroline St
(c) Hospital or institution: 3-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 S Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rufus Manuel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Wid.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
72			hr., min.

9. Birthplace Roanoke City Va (Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER 12. Name Jesse Manuel
FATHER 13. Birthplace Roanoke Va
MOTHER 14. Maiden Name Mallory ?
MOTHER 15 Birthplace Roanoke Va

16 (a) Informant William H. Manuel
(b) Address 112 S. Caroline St

17 (a) Burial (b) Date thereof Feb 3-1948 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Elroy O. Wilson

18 (a) Funeral director 1040 Baltimore
(b) Address
19 (a) 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

FEB 3

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30 1948, at 8:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 27 1948 to Jan. 30 1948 and that I last saw h alive on Jan 30 1948.

Immediate cause of death Uremia — Duration 2 days
Due to Chr. Cardio-renal disease — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. H. Feury M. D.
Address 1420 E. Chase Date signed 2-2-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G59745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1647

G59745 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 41
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 230 Harrison St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME OTIS FAULKNER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1901

8. AGE: Years	Months	Days	If less than one day
46	8	13	hr. min.

9. Birthplace South Caroline (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Faulkner
13. Birthplace S. C.

MOTHER
14. Maiden Name Alice Hood
15. Birthplace S.C.

16 (a) Informant Alice Faulkner
(b) Address 417 Fulton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-5-1948 (month) (day) (year)
(c) Cemetery or crematory Gibbonton Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Sam. H. Stallcup
(b) Address 1631 Druid Hill Ave

19 (a) 2 1948 (Date received by registrar) (b) Victor Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1, 1948, at 8.15 A M

21. I certify that I took charge of the remains described above, held an autopsy Mercy Hospital thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock and Infection

Due to Self inflicted wound of the neck involving the trachea, esophagus, great vessels.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-29-48 at 12.55 p. M.
(b) Where did injury occur? 230 Harrison St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
Nature of injury Sharp instrument

23. Signature Dr. John R. Davis, by [illegible] M.D. Medical Examiner.
Date signed 2-3-48

VS 191

over

G59746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G59746 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1202 Valley Ln.
(c) Hospital or institution:
Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Kent
(c) City or town Rock Hall
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Crouch

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	W

6 (b) Name of husband or wife July 27 1873

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Chas Crouch

8. AGE: Years	Months	Days	If less than one day
72	6	7	hr. min.

9. Birthplace Rockhall Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business (kind)

FATHER
12. Name John Blackistone
13. Birthplace Kent Co. Maryland

MOTHER
14. Maiden Name Julia Leary
15. Birthplace Kent Co. Maryland

16 (a) Informant Gill Linton Hall
(b) Address 1202 Valley Ln.

17 (a) Burial (b) Date thereof Feb. 5 1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Wesley Chapel
Location Rock Hall, Maryland

18 (a) Funeral director Marvin V. Williams
(b) Address Chestertown Maryland

FEB 2 1948 Marvin V. Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3 1948, at 7:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1948 to Feb 3 1948, and that I last saw her alive on Feb 2 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	5 days
Due to	
Due to	
Other Conditions Arterio Sclerosis	5 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Av Date signed 2/3/48

VS 150

G59747 Carter ✓ G59747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 111a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: University Hospital 19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1730 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** George Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 47 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Jack Carter.
13. Birthplace Md.

MOTHER
14. Maiden Name Mary
15. Birthplace Md.

16 (a) Informant Estelle Lawrence
(b) Address 1730 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 3, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Ambrose
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St. Remsenburg Norfolk, Md.

19 (a) 2 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 1948, at 11:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-26 1948 to 1-30 1948, and that I last saw him alive on 1-30 1948.

	Duration
Immediate cause of death Cerebral + myocardial anoxia	
Due to Pulmonary infarction and myocardial failure, acute.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary inf. + congestion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred R. McDaniel Jr. M. D.
Address University Date signed 1/31/48

VS 150

X

G59748

JL - 115139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. G59748

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 18-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 48 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1069 W. Fayette St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Naomi Hanes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1929

8. AGE: Years 18 | Months 10 | Days 9 | If less than one day ..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Henry

13. Birthplace S. C.

MOTHER 14. Maiden Name Lucy Lawson

15. Birthplace Md.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 3, 1948 (month) (day) (year)

(c) Cemetery or crematory Western Star,

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N Schroeder St Huntingtown Williams, Md

19 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29 1948, at 9.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 11 1947 to Jan. 29 1948, and that I last saw her alive on Jan. 29 1948.

	Duration
Immediate cause of death: Acute cardiac failure	
Due to: Severe Hemoptysis	
Due to: Active Rheumatic Carditis	
Due to: with Mitral Stenosis	8 years
Other Conditions: Near Term Pregnancy	

(Include pregnancy within 3 months of death)

Date of operation Post mortem Caesarean Section

Major findings of operation: Delivered of live female Term male infant

of autopsy: Mitral stenosis - Hemorrhage Pleura Lung pericardium

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Harry Cohen M. D.

Address Balto City Hospitals Date signed 1-30-48

PHYSICIAN

Underline the cause to which death should be charged statistically.

VS 150

G59749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1577

G59749
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 205 N. Arlington Ave.
(c) Hospital or institution:
18-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 N. Arlington Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vernon HURSEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1929.

8. AGE: Years	Months	Days	If less than one day
18	9	28	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John W. Hersey
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Bessie Anderson.
15. Birthplace Baltimore, Md.

16 (a) Informant Edith Hersey
(b) Address 205 N. Arlington Ave

17 (a) Burial (b) Date thereof Feb. 5 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs. Katie R. Willia
(b) Address 322 N. Schroeder St

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 30 1948, at M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ or accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Congenital malformation of brain.
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrell M.D.
Medical Examiner.

Date signed 1/31/48

VS 181

X

G59750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

126

G59750

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Sinai Hospital 19-4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 1714 Walbrook ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME FRANK G. MILLER

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-3215

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Sophie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 26, 1879

8. AGE: Years	Months	Days	If less than one day
68	8	6	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Candy maker

11. Industry or business Candy Factory

FATHER 12. Name John Miller

FATHER 13. Birthplace Md

MOTHER 14. Maiden Name Hoff

MOTHER 15. Birthplace Md

16 (a) Informant Mrs. Sophie Miller

(b) Address 1714 Walbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 5/48 (month) (day) (year)

(c) Cemetery or crematory Meadowridge

Location Laurel, Md

18 (a) Funeral director Harry H. Leitzke

(b) Address 4101 Edmondson ave

FEB 3 1948 (Date received by registrar) (b) Registrar Washington, D.C.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/25 1948 to Feb 2 1948 and that I last saw h. alive on Feb 2 1948.

Immediate cause of death – Coronary heart disease, old myocardial infarction, – Carcinomatosis of colon

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2/2/48

Major findings of operation: Calculi in the common duct

of autopsy:

Duration
3 Years

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature S. H. Anderson M. D.

Address Sinai Hospital Baltimore Md Date signed 2-2-48

Chester J. Lubinski, M. D.

per: Howard J. Anderson, M.D. X

G59751

BALTIMORE CITY HEALTH DEPARTMENT ✓ G59751
Registered No.

CERTIFICATE OF DEATH 131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2900 Gwindon Avenue
(c) Hospital or institution: 27-24
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 Gwindon Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lucinda C. Reagle

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1858

8. AGE: Years	Months	Days	If less than one day
89	1	24	hr. min.

9. Birthplace Manchester, Maryland (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Jacob Reagle
13. Birthplace Carroll Co., Maryland

MOTHER
14. Maiden Name Elizabeth Nunamaker
15. Birthplace Carroll Co., Maryland

16 (a) Informant Mrs. A. Howard Sullivan
(b) Address 2900 Gwindon Ave., Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/1948 (month) (day) (year)
(c) Cemetery or crematory Lutheran Church Cem.
Location Manchester, Maryland

18 (a) Funeral director Howard A. Gill
(b) Address Pocomoke City, Maryland

19 (a) (Date received by registrar) Huntington Williams M.D. (Registrar)

FEB 3 1948

VS 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Febraary 2 1948, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1948 to Feb 2 1948, and that I last saw h.r alive on Feb 1 1948

Immediate cause of death
Chr. Myocarditis — Duration 1946
Due to
Due to
Other Conditions Chr. Substitute nephritis — Duration 1946
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Bowen M. D.
Address 166 W. Main St Date signed 2/3/48

930

G59752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G59752 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St.
(c) Hospital or institution: Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME alice Miles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C.	W.

6 (b) Name of husband or wife Ignatius Miles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1866

8. AGE: Years	Months	Days	If less than one day
82	-	21	hr. min.

9. Birthplace St. Mary's Co. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Sister Inds Home Poor
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 4 1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wondella
(b) Address 900 East Biddle St

19 (a) (Date received by registrar) (b) Registrar

FEB 6 1948

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2, 1948; at 12 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1948, to Feb 2 1948, and that I last saw her alive on Feb 2 1948.

Immediate cause of death	Duration
Edema Lungs	4 days
Due to	
Due to Chronic Myocarditis	5 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall

Address 1631 E. North Ave Date signed 2/3/48 M. D.

X

G59753
ff 117101

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93?

G59753
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 26-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 6 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4911 Eastern Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elwin Wirt (Mr.) Swisher
3 (b) If veteran, name war
3 (c) Social Security Account No. 236-4-366

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mrs. Wilma N. Swisher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 14, 1906

8. AGE: Years	Months	Days	If less than one day
41 (42?)	9	17	hr. min.

9. Birthplace Jane Lew?, Lewis Co., W. Va.
(Town, county, and state)
10. Usual Occupation electrician
11. Industry or business Beth Steel - Sparrows Pt.

FATHER
12. Name ? Wirt Swisher
13. Birthplace ? Lewis Co. W. Va.

MOTHER
14. Maiden Name ? Mary Beechley
15. Birthplace ? Lewis Co. W. Va.

16 (a) Informant Records - Baltimore City Hospitals
(b) Address 4940 Eastern Avenue, Wirt Swisher, Jane Lew, W. Va.
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-3-48 (month) (day) (year)
(c) Cemetery or crematory I.O.O.F. Fairview
Location Jane Lew, W. Va.
18 (a) Funeral director Howard N. Blight Jr.
(b) Address 4914 Belair Road
19 (a) (Date received by registrar) Huntington Williams, M.D. Registrar

FEB 3 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 1948, 8:15A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1948, to Feb. 1 1948, and that I last saw him alive on Feb. 1 1948.

Immediate cause of death	Duration
Congestive Heart Failure	3 hrs
Due to Hypertensive Heart Disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William M. Straight M. D.
Address Balt City Hospitals Date signed 2-3-48

VS 150 TO BE APPROVED BY MEDICAL EXAMINER'S OFFICE OK J.R. Davis, M.D.

G59754

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G59754 Registered No. 178 B

MARGIN RESERVED FOR BINDING

...TE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The ...s especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 4-W
(b) Street Address
(c) Hospital or institution: University Hospital DIM
(d) Length of stay in hospital or inst. (yrs., mos., or days) DIM
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits write RURAL and give town)
(d) Street No. 731 W Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) N
If yes, name country

3 (a) FULL NAME Albert Petrauskas

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. 220-05-2868

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1922

8. AGE: Years 26 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name William Petrauskas
13. Birthplace Leth

MOTHER
14. Maiden Name Mary Moskevich
15. Birthplace Leth

16 (a) Informant Rose Petrauskas
(b) Address 731 W Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 4 48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Joseph Kasemskas
(b) Address 60 [illegible] Baltimore, Md.

19 (a) Date received by local registrar (b) Huntington-Williams, Md.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1948, at 8:45 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the cause of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to Carbon Monoxide poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 31st January 1948 at 8:15 P.M.
(b) Where did injury occur 829 Hollins St.
(c) Did injury occur at home, on farm, industrial place, in public place? Garage at above address While at work? No
(d) Means of injury Working on Car with motor running

23. Signature William H Helfrich M.D.
Medical Examiner.
Date signed 2/1/48

G59755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

✓ G59755

Registered No.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5506 Alhambra av

(c) Hospital or institution: 27-8

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)

(d) Street No. 5506 Alhambra av (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret McGee.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Thomas B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14-1859

8. AGE: Years 88 | Months 8 | Days 19 | If less than one day hr. min.

9. Birthplace Ireland. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER

12. Name Daniel Smith

13. Birthplace Ireland.

MOTHER

14. Maiden Name Ann Sheridan

15. Birthplace Ireland.

16 (a) Informant Mary Kelly

(b) Address 5506 Alhambra av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel

Location Old Frederick Rd.

18 (a) Funeral director John J. McGee

(b) Address 4501 Hammond av

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

FEB 3 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2- 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1/19 47 to 2/2/19 48, and that I last saw h alive on 2/30/19 48

Immediate cause of death	Duration
Hypernephroma Gastric	1 week
Due to Myocardosis	6 mos
Due to Senile Arteriosclerosis	1 year
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Thomas F. White M. D.

Address 532 E. 22nd St. Date signed 2/3/48

X

G59756

BALTIMORE CITY HEALTH DEPARTMENT ✓ G59756 Registered No.

CERTIFICATE OF DEATH 937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2303 Duker St.
(c) Hospital or institution: 1-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2305 Duker St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Kusyk

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-26-3852

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Anna Kusyk
(b) Address 2305 Duker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 5/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozaczynski
(b) Address 1930 Eastern Ave

19 (a) 1948 (Date rec'd by Registrar) (b) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1 1948, at 9 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 29 1948, to — 19—, and that I last saw him alive on Jan 30, 1948

Immediate cause of death: Cardio vascular arteriosclerosis with hypertension — Duration: years

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sigmund R. Nowak M.D.
Address 406 S. Path. Ph. Ave. Date signed 2/2/48

G59757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

G59757

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 2-1
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 404 E. Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Chudzik
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Effie Chudzik
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7-16-77

8. AGE: Years	Months	Days	If less than one day
70	6	16	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Cabinet Maker
11. Industry or business

FATHER
12. Name John Chudzik
13. Birthplace Poland

MOTHER
14. Maiden Name Anna Shromick
15. Birthplace Poland

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 4/48 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore
18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastern Ave.
19 (a) 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1 1948, at 8:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30 1948 to Feb 1 1948 and that I last saw him alive on Feb 1 1948.

	Duration
Immediate cause of death: Pulmonary embolism	5 min.
Due to: 2 Femoral thrombophlebitis	2
Due to:	
Other Conditions: Arteriosclerotic heart disease	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Mid surgical

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Victor A. McKusick
Address Hosp. Date signed 2/1/48 M. D.

VS 150

100 B

G59758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59758

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 216 S. Exeter St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-
(e) Length of stay in Baltimore (yrs., mos., or days) 34 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 216 S. Exeter St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Pompa

3 (b) If veteran, name war none

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~Living~~ Dominic Pompa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14 1893

8. AGE: Years	Months	Days	If less than one day
54	3	18	hr. min.

9. Birthplace Castellalto- Teramo Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Vincenzo Cozzi
13. Birthplace Italy

MOTHER
14. Maiden Name Mariassunta Ipaldi
15. Birthplace Italy

16 (a) Informant Dominic Pompa (Husband)
(b) Address 216 S. Exeter St.

17 (a) Burial (b) Date thereof Feb. 4 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) FEB 3 1948 Huntington Williams, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1 st 1948 at 7 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1st 1947 to Feb 1st 1948 and that I last saw h-- alive on 2/1 st 1948

Immediate cause of death Cerebral Hemorrhage — Duration 11 hours
Due to Hypertension — one year
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Jankel M. D.
Address 100 N. Milton Ave Date signed 2/3/48

VS 188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 659759

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Lexington St.
(c) Hospital or institution:
Aged Homme + Aged Mens Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1403 N Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harriet Trow Wells

3 (b) If veteran, name war: NV
3 (c) Social Security Account No.: none
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Charles B
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 14. 1868 1858
8. AGE: Years 79 | Months 1 | Days 19 | If less than one day hr. min.
9. Birthplace Central Park Long Island N.Y.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Anton Henry Trow
13. Birthplace Unknown

MOTHER
14. Maiden Name Hannah Ann Sands
15. Birthplace Unknown

16 (a) Informant L. L. Read Supt.
(b) Address 1400 N. Lexington St.
17 (a) Burial (b) Date thereof 2/4/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Catchogue
Location Catchogue L. I. N.Y.
18 (a) Funeral director Wilson Bros
(b) Address 1219 N. Eutaw St.
19 (a) FEB 2 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2, 1948, at 10.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1948, to Feb 2 1948, and that I last saw h TK alive on Feb 1 1948.

Immediate cause of death Cardio-Respiratory Failure — Duration
Due to Pulmonary Thrombosis
Due to
Other Conditions Generalized arteriosclerosis C-V-D.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maryland Edward Day M. D.
Address 4-E-33rd St Balto 18 Date signed Feb 3 1948

V S 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59760

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G59760 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2707 ALLENDALE Rd.
(c) Hospital or institution:

15-8

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2707 ALLENDALE Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DORTHEY J. TWILLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	divorced

6 (b) Name of husband or wife C. Merritt Twilley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1904

8. AGE: Years	Months	Days	If less than one day
44		12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Robert C. Jones
13. Birthplace Md.

MOTHER
14. Maiden Name Ella A. Cranmer
15. Birthplace N. J.

16 (a) Informant Mrs. R. C. Jones
(b) Address 2707 Allendale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/48 (month) (day) (year)
(c) Cemetery or crematory DRUID RIDGE
Location Pikesville Md.

18 (a) Funeral director Martin Fahey & Sons
(b) Address 1827 W. North Ave.

19 (a) Date Rec'd (Registrar) (b) Huntington Williams M.D. Registrar

FEB 3 1948

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-31- 1948, at 9.38 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-1947, to 1-31-1948, and that I last saw h[illegible] alive on 1-31-1948

Immediate cause of death
Carcinoma of Breast (Lft) — Duration 4 yrs.
Due to Generalized Carcinomatosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard J. Whelan M. D.
Address 2007 Garrison Blvd. Date signed 2-2-48

G59761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G59761
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 320 Radnor Rd.
(c) Hospital or institution: 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ~~Baltimore~~
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 320 Radnor Rd.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Etta Susan McAbee.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow.

6 (b) Name of husband or wife Edward McAbee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1862

8. AGE: Years	Months	Days	If less than one day
85	4	3	hr. min.

9. Birthplace New Freedom, Pa. R.D.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own home.

FATHER
12. Name Joseph W. Wantland
13. Birthplace Penna.

MOTHER
14. Maiden Name Mary J. Taylor.
15. Birthplace Penna.

16 (a) Informant Mrs. Paul Walter.
(b) Address 320 Radnor Rd. Baltimore

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Feb. 6, 1948. (month) (day) (year)
(c) Cemetery or crematory New Freedom.
Location New Freedom, Pa.

18 (a) Funeral director Jacob Hartenstein
(b) Address New Freedom, Pa.

19 FEB 4 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3, 1948 at 1:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1947 to Feb 3 1948, and that I last saw HER alive on Feb 2 1948.

Immediate cause of death	Duration
Acute Coronary Occlusion	1 day
Due to Arteriosclerotic Heart Disease	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Dawson M. D.
Address 4808 Harford Rd. Date signed 2/3/48

G59762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

G59762 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st St.
(c) Hospital or institution:
U S Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 41 days
(e) Length of stay in Baltimore (yrs., mos., or days) 41 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Wicomico
(c) City or town Mardela Springs
(If outside city or town limits, write RURAL and give town)
(d) Street No. - (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Johnson, James Arthur

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	w	widower

6 (b) Name of husband or wife Rose Baer Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 16, 1898

8. AGE: Years	Months	Days	If less than one day
49	5	17	hr. min.

9. Birthplace Avary, Ga. (Town, county, and state)
10. Usual Occupation Seafarer-captain
11. Industry or business

FATHER
12. Name Mary Adams
13. Birthplace Ga.

MOTHER
14. Maiden Name John Johnson
15 Birthplace Ga.

16 (a) Informant Records
(b) Address U. S. Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 4-48 (month) (day) (year)
(c) Cemetery or crematory Forest Hills
Location Baltimore Co.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave.

19 (a) FEB 4 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

mhk 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2, 1948 at 8:35PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 23, 1947 to Feb. 2, 1948, and that I last saw him alive on Feb. 2, 1948.

	Duration
Immediate cause of death 1- Bronchopneumonia,	4 days
2-Carcinoma, right tonsillar fossa, with extension to base of skull	6 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surg. M. D.
Address U. S. Marine Hospital Date signed 2-2-48

G59763
AB-105173

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 146a

G59763 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1800 McCulloh St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Gassaway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Divorced

6 (b) Name of husband or wife Lelia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 10-1894

8. AGE: Years	Months	Days	If less than one day
53	10	24	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Timothy Gassaway
13. Birthplace Md.

MOTHER
14. Maiden Name Laura Neugen
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-48 (month) (day) (year)
(c) Cemetery or crematory White Rock
Location Bennett Pond Co. Md.

18 (a) Funeral director C. M. Walter
(b) Address Winfield Md.

19 (a) [illegible] (Date rec'd by Registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3 1948 at 12.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-11- 1946 to 2-3- 1948, and that I last saw h im alive on 2-3- 1948.

Immediate cause of death Carcinoma of Esophagus — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1/26/48

Major findings of operation: Carcinoma of Esophagus

If autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. S. Farraco M.D.
Address Baltimore City Hosp Date signed 2/3/48

VS 150

G59764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59764

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 BELLONA AVE
(c) Hospital or institution: EDGEWOOD NURSING HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-17
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 6000 BELLONA AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH WELSH

3 (b) If veteran, name war	3 (c) Social Security Account No.
NONE	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 15, 1860

8. AGE: Years	Months	Days	If less than one day
87	3	17	hr. min.

9. Birthplace BALTIMORE, Md. (Town, county, and state)
10. Usual Occupation WATCHMAN
11. Industry or business

FATHER 12. Name	UNKNOWN
13. Birthplace	"
MOTHER 14. Maiden Name	"
15 Birthplace	"

16 (a) Informant
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 5 1948 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location BALTIMORE, Md.
18 (a) Funeral director WILLIAM COOK INC
(b) Address 1217 ST. PAUL ST.
19 (a) FEB 4 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 2 1948 at 6.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24 1948 to Feb 2 1948 and that I last saw him alive on Feb 2 1948

Immediate cause of death	Duration
(a) Chronic Myocarditis	indef
Due to	
Due to	
Other Conditions (Include pregnancy within 3 months of death)	
(b) Senile Dementia	indef
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Richardson M.D.
Address 117 W. 25th St. Date signed Feb 5 1948

H.H. Richardson 925

659765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

659765 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2405 E Preston St
(c) Hospital or institution: 8-3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 2405 E Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Doblitz

3 (b) If veteran, name war
3 (c) Social Security Account No. 212-18-8307A

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Jennie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18 1874

8. AGE: Years 73 | Months 7 | Days 4 | If less than one day hr. min.

9. Birthplace Ga (Town, county, and state)
10. Usual Occupation Grocery man
11. Industry or business

FATHER
12. Name Milton Doblitz
13. Birthplace Ga

MOTHER
14. Maiden Name Martha Horne
15. Birthplace Ga

16 (a) Informant Mrs Jennie Doblitz
(b) Address 2405 E Preston St
17 (a) June (b) Date thereof 2-5-48 (month) (day) (year)
(burial, cremation, or removal)
(c) Cemetery or crematory London Park
Location Baltimore Md
18 (a) Funeral director Milton J Doc
(b) Address 1214 E Pratt St
19 (a) FEB 4 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 1948 at 7:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 3, 1948 to Feb 2, 1948.
and that I last saw h... alive on Feb. 1, 1948.

Immediate cause of death: Coronary occlusion — Duration: 3 yrs.
Due to Arteriosclerosis
Due to
Other Conditions Broncho pneumonia — 7 days.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas E Dingwall M.D.
Address 1613 E. North Ave. Date signed 2-3-48

X

VS 150

G59766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G59766

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Harford Rd
(c) Hospital or institution: Harford Nursing Home 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 713 E Preston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice A. Hiestand

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harry S

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16 1865

8. AGE: Years 82 | Months 3 | Days 17 | If less than one day: hr. min.

9. Birthplace York Co Pa
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wm DeHoff
13. Birthplace Pa

MOTHER
14. Maiden Name Elizabeth Bowman
15. Birthplace Pa

16 (a) Informant Irvin H Hiestand
(b) Address 506 Oakland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/48 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Williams & Lee
(b) Address 519 E Fayette St

19 (a) FEB 4 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1948, at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1948 to Feb 3 1948 and that I last saw her alive on Feb 2 1948.

Immediate cause of death: Bronchio-pneumonia — Duration: 3 days.
Due to: Arteriosclerosis generalized
Due to:
Other Conditions: Ca - cervix — 2
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) ~~Did~~ injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis F. Klemm M.D.
Address 2623 E. Monument St Date signed 2/7/48

VS 150

G59767

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G59767 Registered No. 133B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital 22-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto City (If outside city or town limits, write RURAL and give town)
(d) Street No. 533 W. Barre (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Nathaniel Reid

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Mildred Reid
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1/10/1910 (1/10 K(1/7/8) 1910)

8. AGE: Years	Months	Days	If less than one day
38	-	23	hr. min.

9. Birthplace Rockwell N.C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Brick Yard

FATHER
12. Name Unknown
13. Birthplace ?

MOTHER
14. Maiden Name Anna Mills
15. Birthplace North Carolina

16 (a) Informant Mildred Reid
(b) Address 533 W Barre St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-5-48 (month) (day) (year)
(c) Cemetery or crematory Rockwell
Location North Carolina

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) FEB 4 1948 (Date rec'd by registrar) (b) Interring for Williams M.E.

MEDICAL CERTIFICATION

20. **DATE OF DEATH** Feb 2 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-9 1948, to 2-2 1948, and that I last saw him alive on 2-2 1948.

Immediate cause of death	Duration
Renal failure	
c. potassium intoxication	
Uremia	
Due to Polycystic disease of kidneys	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. **Signature** Fred L. McCrumb jr. M. D.
Address University Hosp. Date signed 2-2-48

VS 153

659768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

659768 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2330 Madison ave
(c) Hospital or institution: 13-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2330 Madison ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Addie P. Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
65 6 4			hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Levi Gant
13. Birthplace Md

MOTHER
14. Maiden Name Annie Herbert
15. Birthplace Md

16 (a) Informant Minnie L. McCaddon
(b) Address 1926 15th N.W. Washington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-43 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A. Stayer
(b) Address 1432 W. Saratoga St.

19 FEB 4 1948 (Date rec'd by registrar) (b) Huntingtown, Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1 1948, at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 24 1947, to 1 Feb. 1948, and that I last saw her alive on 1 Feb. 1948.

Immediate cause of death	Duration
Congestive Heart Failure	1 month
Due to Rheumatic Heart Disease	?
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clifford O. Miranda M. D.
Address 1909 Druid Hill Date signed 2-4-48

V S 150

G59769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

G59769 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 28 N. Morley St.
(c) Hospital or institution: 20-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 28 N. Morley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EDITH M. RITZ

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: John A. Ritz, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 14, 1874

8. AGE: Years: 73 | Months: 3 | Days: 17 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: James A. Gorsuch
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Susan Little
15. Birthplace: Maryland

16 (a) Informant: Mr. John A Ritz, Sr.
(b) Address: 28 N. Morley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/48 (month) (day) (year)
(c) Cemetery or crematory: Balto. Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 FEB 4 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31, 1948, at 10:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27 1944 to Jan 31 1948, and that I last saw h[illegible] alive on Jan 30, 1948.

Immediate cause of death	Duration
Coronary thrombosis	1 hour
Due to	
Due to	
Other Conditions Acute bronchitis	2 weeks

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Kennard Gaff M.D.
Address 3101 W Baltimore Date signed 2/3/48

VS 150

X

body to Johns Hopkins Hospital morgue

G59770

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. G59770

CERTIFICATE OF DEATH

Med Exam Case 194a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL (6-)
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 427 N. Curley, St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA SMRHA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widow
(b) Name of husband or wife: Frank
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1878

8. AGE: Years 69 | Months 7 | Days 21 | If less than one day: hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name John Jandik
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Marie Boucek
15. Birthplace Czechoslovakia

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-5-5 E. Madison Street Huntington Hotel, Md.

19 (a) 2/4/48 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2- 1948 at 3 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death MYOCARDIAL INFARCTION — Duration

Due to ARTERIOSCLEROSIS OF CORONARY ARTERIES

Due to

Other Conditions CHRONIC PYELONEPHRITIS (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sidney Stephens

Address Johns Hopkins Hosp. Date signed 2/4/48

For H. R. Oakes by Howard J. Wiencke, M.D.

VS 150

be approved by Chief Medical Examiner.

59771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

837

Registered No. 59771

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland 2-7-17

(b) Street address Belvedere & Greenspring Ave

(c) Hospital or institution: Levindale Hebrew Home & Infirmary

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3½ months

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. LEVINDALE (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Kate Finneman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Joel

13. Birthplace Russia

MOTHER 14. Maiden Name Pauline

15. Birthplace Russia

16 (a) Informant Abe Finneman

(b) Address 3300 Springdale Ave

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 2-4-48 (month) (day) (year)

(c) Cemetery or crematory

Location Baltimore Hebrew

18 (a) Funeral director Jack Lewis Inc

(b) Address 2166 Eutaw Place

19 (a) FEB 4 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3rd 1948, at 8:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 15th 1948 to February 3 1948 and that I last saw h[illegible] alive on Feb. 3rd 1948.

Immediate cause of death	Duration
Acute heart failure	
Due to	
Due to decubital	
Other Conditions Status post hemiplegiam, decubitus ulcers (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Jerome J. Blumberg M. D.

Address Levindale Hebrew Home Date signed 2/3/48

VS 150

G59772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G59772

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2906 Allendale Rd
(c) Hospital or institution: 15-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2906 Allendale Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carrye Lamm Silverstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 50 | Months | Days | If less than one day: hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Charles

13. Birthplace Germany

MOTHER 14. Maiden Name Sarah

15. Birthplace Germany

16 (a) Informant Jacob D Silverstein

(b) Address 2906 Allendale Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-4-48 (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship

Location

18 (a) Funeral director Jack Lewis Inc

(b) Address 2106 Eutaw Place

FEB 4 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-3-1948 at 6:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1947 19__ to Feb 2 1948, and that I last saw h.r alive on Feb 2 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage and	2 wks
Due to Jaundice, undetermined origin	4 yrs.
Due to Enlarged liver, Cirrhosis	4 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dan'l Robinson

Address 435 Guilford Ave Date signed 2/3/48 M D

VS 150

C59773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C59773 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 MONTH 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 26 AVON AVE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. EMMA SOMOGYI (STEIN)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife JULIUS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/1/81

8. AGE: Years 66 | Months 4 | Days 1 | If less than one day ____ hr. ____ min.

9. Birthplace HUNGARY (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name Stein

13. Birthplace Hungary

MOTHER 14. Maiden Name

15. Birthplace Hungary

16 (a) Informant Julius Somogyi

(b) Address 26 Avon Ave., Dundalk Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 5, 1948 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Eastern Blvd.

18 (a) Funeral director Roland L. Fisher

(b) Address 2112 Dundalk Ave.

19 (a) FEB 4 1948 (Date rec'd by Registrar) (b) Kensington Williamsport Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/2 1948, at 5 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/25 1947 to 2/2 1948, and that I last saw her alive on 2/2 1948.

Immediate cause of death CARDIO-RESPIRATORY FAILURE — Duration

Due to ARTERIOSCLERDTIC

Due to CARDIO-VASCULAR DISEASE

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry J. Houska M.D.

Address St. Jos. Hosp. Date signed 2/2/48

V S 150

G59774

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G59774

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 616 S. Monroe St.
(c) Hospital or institution: 20-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 616 S. Monroe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James F. Cadogan

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 19th 1886

8. AGE: Years	Months	Days	If less than one day
61	4	15/14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business B & O R.R.

FATHER
12. Name James Cadogan
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace Ireland

16 (a) Informant Mrs Mary E. Cadogan
(b) Address 616 S. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins St

FEB 4 1948 (Date Fee Rec'd by Registrar) Huntington Willis (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3rd 1948, at 12 Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1948 to Feb 3 1948, and that I last saw him alive on Feb 3 1948.

Immediate cause of death	Duration
Acute Pulmonary Oedema	1 Hour
Due to Acute coronary occlusion	1 day
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan Rackusin M. D.
Address 206 S. Gilmor St. Date signed 2-4-48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159775 — 108 — Registered No. 159775

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — 3.2
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 217 Paniident St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Cook.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Married

6 (b) Name of husband or wife Daisy Cook
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-29-1887

8. AGE: Years	Months	Days	If less than one day
61	6	-	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Dyers for Co

FATHER
12. Name Charles Cook
13. Birthplace Md

MOTHER
14. Maiden Name Florence Wortche
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 4 1948 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Frankintown

18 (a) Funeral director John D. Mitchell & Sons
(b) Address 1900 Eastern Place

19 (a) FEB 4 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 29 1948 at 1.20 M — A

21. I certify that death occurred on the date above stated; that I attended deceased from Jan - 28 1948 to Jan - 29 1948 and that I last saw him alive on Jan - 29 1948

Immediate cause of death	Duration
Fatal Pneumonia	3
Due to Pneumococcus Type I	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fedrick A. McKusick
Address Johns Hopkins Hosp Date signed 2/2/48

VS 150

G59776

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G59776 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 720 N. Saratoga (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Zemmie Riley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
f	C	married

6 (b) Name of husband or wife Alfred
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3 1891

8. AGE: In Years	Months	Days	If less than one day
56 59	10	29	hr. min.

9. Birthplace Ga. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name West Carter
13. Birthplace Ga.

MOTHER
14. Maiden Name Jasmie Witt
15. Birthplace Ga.

16 (a) Informant Alfred Riley
(b) Address 720 - Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-5-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location
18 (a) Funeral director A. Stellstead
(b) Address 918 - Druid Hill Ave.

19 48 FEB 4 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 181 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/1/48 19 at 10:20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D. Medical Examiner.
Date signed 2/2/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C59777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C59777 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 954- Forest St.
(c) Hospital or institution: Md. Penitentiary Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Under 1 year 1939 to Jan 1948
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs +

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County Lancaster Co
(c) City or town Lottsburg - Md. Penitentiary
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Nelson

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Married

6 (b) Name of husband or wife Mary Smith
6 (c) If alive, give age 9 years

7. Birth date of deceased (mo., day, yr.) 56-11 mo. 30 day

8. AGE: Years	Months	Days	If less than one day
56	11	30	1/31 / 1891 hr. min.

9. Birthplace Lancaster Co. Va. (Town, county, and state)
10. Usual Occupation Chef. ✓
11. Industry or business

FATHER
12. Name Louis Nelson
13. Birthplace ~~Lancaster Co.~~ Penna.

MOTHER
14. Maiden Name Eleanor Smith
15. Birthplace Lancaster Co. Va.

16 (a) Informant Daughter - Dorothy Griffin
(b) Address 905 - Harlan Ave Balto Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof ~~January~~ 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A Halstead

18 (a) Funeral director 918 Bond St
(b) Address

19 Filed Jan 1948 (Date rec'd by Registrar) (b) Huntington Williamsport Pa

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 1948, at 9 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 9 1948 to Jan 30 1948, and that I last saw him alive on Jan. 29 1948.

Immediate cause of death Massive Cerebral Hemorrhage — Duration

Due to Hypertensive Cardio Vascular Renal Disease

Due to Chronic Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry W. D. Holges M. D.
Address Md Penitentiary Date signed 1-30-48

VS 150 — 1 1A

G59778

AB-116701

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

51B

G59778 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 13-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14days
(e) Length of stay in Baltimore (yrs., mos., or days) 70yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3710 Clipper Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George P. Kain

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Emily

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5- 1872

8. AGE: Years	Months	Days	If less than one day
75	7	27	hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER 12. Name William Kain

13. Birthplace Baltimore County, Md.

MOTHER 14. Maiden Name Annie Hartman

15. Birthplace Baltimore County, Md.

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Feb. 5 1948 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location North Ave.

18 (a) Funeral director C. Bernard Kelly Mortuary

(b) Address 2645-47 W. Chestnut Ave.

19 (a) Date rec'd by Registrar FEB 6 1948 (b) Registrar's address Towson, Md.

MEDICAL CERTIFICATION PM

20. DATE OF DEATH Feb. 2- 1948, at 12.15M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-18- 1948 to 2-2- 1948, and that I last saw h im alive on 2-2- 1948.

Immediate cause of death Carcinoma of Prostate with Metastases — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1/22/48

Major findings of operation: Carcinoma of Prostate

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. S. Parsons

Address Baltimore City Hospitals Date signed 2/3/48 M. D.

MSa 150 # 3414

X

659779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC-48-01919 ✓ 84a

659779

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2-2
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County .....
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 316 S. Wolfe St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** Baby Girl Peck

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1-24-48

8. AGE: Years	Months	Days	If less than one day
0	0	0	19 hr. 40 min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER — 12. Name Edward Peck

13. Birthplace Virginia

MOTHER — 14. Maiden Name Dolores Rostek

15. Birthplace Baltimore md

16 (a) Informant Mrs Dolores Peck

(b) Address 316 S. Wolfe St Balto

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 1-31-48 (month) (day) (year)

(c) Cemetery or crematory UMH

Location .....

18 (a) Funeral director .....

(b) Address .....

19 (a) FEB 4 1948 (Date received by registrar) Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. **DATE OF DEATH** 1-30 1948, at 6 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-24 1948, to 1-30 1948, and that I last saw her alive on 1-30 1948.

Immediate cause of death Mongolism — Duration .....

Due to ..... — Duration .....

Due to ..... — Duration .....

Other Conditions ..... — Duration .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation .....

of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature E B Chamberlain M. D.

Address Union Memorial Hosp Date signed 1-30-48

VS 180

X

C59780 B C - 4 4 - 0 85 3 BALTIMORE CITY HEALTH DEPARTMENT C59780
H - 116897 CERTIFICATE OF DEATH 159 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5603 Swift Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Walker - Hazel Walker (mother)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1948

8. AGE: Years | Months | Days 1 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Walker
13. Birthplace Md.

MOTHER 14. Maiden Name Hazel Walker
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 1-30-48 (month) (day) (year)
9 AM
(c) Cemetery or crematory B.C.H. Crematory
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) FEB 4 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27 1948, at 8.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 26 1948 to Jan. 27 1948 and that I last saw h im alive on Jan. 27 1948.

Immediate cause of death Atelectasis — Duration 1 day
Prematurity — 1 day
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Prematurity, Atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julian K. Griffin M. D.
Address Balto. City Hosps Date signed 29 Jan 48

G59781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93

Registered No. G59781

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1307 Booth St.
(c) Hospital or institution: 19-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 Booth St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM / STILES

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife: Laura (deceased)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 14 1890

8. AGE: Years	Months	Days	If less than one day
57	smt 11	16	hr. min.

9. Birthplace: Cambridge, Maryland
(City, county, and state)

10. Usual Occupation: Farmer
11. Industry or business

FATHER
12. Name: Linwood Stiles
13. Birthplace: Cambridge, Md.

MOTHER
14. Maiden Name: Eleanor Cornish
15. Birthplace: Cambridge, Md.

16 (a) Informant: Lelia Waters
(b) Address: 1307 Booth St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 4/1948 (month) (day) (year)
(c) Cemetery or crematory: Mt Auburn
Location:

18 (a) Funeral director: Mrs Katie R. Williams
(b) Address: 322 N Schroeder St

19 (a) 1948 (Date received by registrar) (b) Registrar

Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30, 1948, at 8.45 A.M.

21. I certify that I took charge of the remains described above, held an insp.& inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard F. Wellers M.D.
Medical Examiner.
Date signed 1-30-48

X

G59782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G59782 / 1248

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett Ave.
(c) Hospital or institution: Pinewood Conv. Home 9-7
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2546 Robb St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony J. Elmendorf

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 17th 1871

8. AGE: Years	Months	Days	If less than one day
71	1	16	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business American Brewery

FATHER
12. Name Herman Elmendorf
13. Birthplace Prussia

MOTHER
14. Maiden Name Margaret Albert
15. Birthplace Md.

16 (a) Informant Mrs Mary Bierly
(b) Address 4421 4th St Brooklyn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 5th 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo G. Leoke
(b) Address 1761-63 N. Patterson Park Ave

19 (a) (Date rec'd by registrar) (Registrar) Huntington Williams

FEB

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2nd 1948, at 1.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1948, to Feb 2 1948, and that I last saw h~~im~~ alive on Feb 1 1948

Immediate cause of death	Duration
Chr. myocarditis.	2 years
Due to	
Due to	
Other Conditions Scarlet Fever 1st infection.	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. S. Saunders

Address 380 S Belair Rd Date signed 2/3/48 M. D.

VS 150

93

G59783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52 c

G59783 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 84
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2107 E. Mura St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Mullen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mildred.
6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) 1-25-10

8. AGE: Years	Months	Days	If less than one day
38.	-	7	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business Gas fitter

FATHER
12. Name Walter Mullen
13. Birthplace Md.

MOTHER
14. Maiden Name Anna ?
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 4 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Location

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION C

20. DATE OF DEATH Feb - 1 - 1948 at 6.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan - 2 1948 to Feb - 1 - 1948, and that I last saw him alive on Feb - 1 1948.

Immediate cause of death Embolism — Duration

Due to Coronary thrombosis

Due to Arteriosclerosis of aorta

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Gardner M. D.
Address John Hopkins Hosp. Date signed 2-2-48

VS 150

G59784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G59784 Registered No. 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins 7-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Always

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 600 N. Port Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA SCHERER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Emil Scherer

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 69 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER 12. Name John Doemling

13. Birthplace Balto.

MOTHER 14. Maiden Name Dont Know

15. Birthplace Balto

16 (a) Informant Emil Scherer

(b) Address 600 N Port St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 5 (month) (day) (year)

(c) Cemetery or crematory Balto Cem City

Location

18 (a) Funeral director Wilmer Funeral Home

(b) Address 1008 Orleans St

19 (a) FEB 4 (Date rec'd by registrar) (b) Huntington Williamson, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/2/98 19..... at 10:30 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R Davis M.D. Medical Examiner.

Date signed 2/2/98

BALTIMORE CITY HEALTH DEPARTMENT

G59785 JAL - 11449 CERTIFICATE OF DEATH 13B Register 659785

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 3-1
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 S. Bond St. - 31 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Daniel Burns

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Clarie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1912

8. AGE: Years	Months	Days	If less than one day
35	3	16	hr. min.

9. Birthplace Ga. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Jim.
13. Birthplace Ga.

MOTHER
14. Maiden Name Julia Nichols
15. Birthplace S. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 4, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Alvey B. Wilson
(b) Address 1018 Bentley Rd

19 (a) (Date rec'd by Registrar) (b) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30 1948, at 5.09 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-14 1947, to Jan. 30 1948, and that I last saw h im alive on Jan. 30 1948.

Immediate cause of death	Duration
Due to Tuberculosis, Pulmonary	
Far advanced C	
Due to Caseation	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Pulmonary Hge

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William M. Straight M. D.
Address Balto City Hosp. Date signed 1-31-48

FEB 4 1950

X

659786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

33 B

Registered No. 659786

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Lyden house Hospital 8-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 18 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 N. Durham St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME WARFIELD, Warren Melvin

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1st, 1946

8. AGE: Years	Months	Days	If less than one day
1	5	2	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation infant

11. Industry or business "

FATHER
12. Name Melvin Warfield
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Valisette Smith
15. Birthplace Baltimore, Md

16 (a) Informant Valisette Warfield (mother)
(b) Address 1719 N. Durham St

17 (a) Burial (b) Date thereof Feb. 4, 1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director H. Sanford Sons
(b) Address 1649 E. North Ave.

19 (a) FEB 4 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3 1948 at 11a M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1948 to Feb 3 1948, and that I last saw h alive on Feb 3 1948

	Duration
Immediate cause of death Respiratory failure	
Meningitis	1 day
Due to Hemophilus influenza	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Morrison M. D.
Address Lyden house Hospital Date signed 3 Feb 48

V S 150

X

G59787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

§3a ✓ Registered No. G59787

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL 8-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 RUTLAND AVE (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME TERESA LONG (TERESA LONG)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife HARRY LONG
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) 6/11/82

8. AGE: Years 65 | Months 7 | Days 22½ | If less than one day hr. min.

9. Birthplace IRELAND. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Nicholas Boyle
13. Birthplace Ireland

MOTHER
14. Maiden Name Teresa Burnes
15. Birthplace Ireland

16 (a) Informant Mr. Harry Long
(b) Address 1609 Rutland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

FEB 4 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/2 1948, at 9:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1948 to 2/2 1948 and that I last saw her alive on 2/2 1948

Immediate cause of death	Duration
RESPIRATORY FAILURE	
Due to CEREBRAL HEMORRHAGE	
Due to ARTERIOSCLEROSIS	
Other Conditions PYONEPHRITIS (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry J. Hourahan M.D.
Address 6 E. Lexington St. Date signed 2/2/48

G59788 ONN

BALTIMORE CITY HEALTH DEPARTMENT ✓ G59788

CERTIFICATE OF DEATH 937

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: St Joseph's Hosp 27-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6109 Meyer Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Della M Callis Johnston

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Charles Johnston
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 28, 1870

8. AGE: Years	Months	Days	If less than one day
77 (78)	1	6	..... hr. ..... min.

9. Birthplace Mississippi (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name John Callis
13. Birthplace Va

MOTHER
14. Maiden Name Margaret
15. Birthplace .....

16 (a) Informant Dowghter Ada Wolfe
(b) Address 6109 Meyer Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn Md

18 (a) Funeral director Leonard Buck
(b) Address 5305 Harford Rd

19 (a) ..... (Date received by registrar) (b) Huntington Williams, M.D. Registrar

FEB 4 1948

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 1948, at 3:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 1948, to 2-4 1948, and that I last saw her alive on 2-4 1948

Immediate cause of death	Duration
Cardiac Failure	
Due to Arterio sclerotic CVD	
Due to	
Other Conditions Pyelonephritis	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature [illegible] M.D.
Address St Joseph's Hosp. Date signed 2/6/48

X

G59789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

178a

Registered No. G59789

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town Akron
(If outside city or town limits, write RURAL and give town)
(d) Street No. 278 North Arch St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene F. Ohler

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No. 299-03-0956

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Celina Ohler
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 13- 1918

8. AGE: Years 30 | Months — | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace Mansfield Ohio
(Town, county, and state)

10. Usual Occupation Conductor
11. Industry or business B & O. R.R.

FATHER
12. Name Eugene Benton Ohler
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Maria Lea
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Celina Ohler
(b) Address 278 Arch St. Akron Ohio

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb-7-48 (month) (day) (year)
(c) Cemetery or crematory Chestnut Hill Cem
Location Akron - Ohio

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 FEB 4 1948 (Date rec'd by registrar) (b) Inurement for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3, 19 48 at 2 45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, probably accident ☑ or suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to illuminating gas

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death fill in the following:
(a) Date of injury 2/3/48 at Between 12:30 11/2 30 P.M.
(b) Where did injury occur? 1315 N. Charles Street
(c) Did injury occur at home, on farm, industrial place, in public place? Apt. House While at work? No
(d) Means of injury Illuminating gas - gas heater or [illegible]

23. Signature [signature] M.D.
Medical Examiner.
Date signed 2-4-48

VS 191

G59790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G59790 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1911 Lemmon St.
(c) Hospital or institution: 20-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1911 Lemmon St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Mews

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Wm. Mews.
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1866

8. AGE: Years	Months	Days	If less than one day
81	4	23	hr. ____ min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Handy

FATHER
12. Name Edward Johns
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant James W. Mews.
(b) Address 1911 Lemmon St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director Geo. L. Eckhardt
(b) Address 2101 Frederick Ave.

19 (a) FEB 4 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3, 1948 at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1948 to Feb 3 1948 and that I last saw h[illegible] alive on Feb 3 1948

Immediate cause of death	Duration
Acute Cardiac Dilitation	1 day
Due to Hypertensive Cardio Vascular disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Glassman M. D.
Address 2607 Eastern Ave Date signed Feb 4 1948

659791 Reg

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

659791 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 132 N. Port
(c) Hospital or institution: 6-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 132 N. Port St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Matthew Lindra

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Petronilla Lindra

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22, 1868

8. AGE: Years 79 | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Joseph Lindra
13. Birthplace Bohemia

MOTHER
14. Maiden Name Not known
15. Birthplace Bohemia

16 (a) Informant Helen Lindra
(b) Address 132 N. Port St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 5 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balt Md

18 (a) Funeral director Frank Goodwin
(b) Address 900 N. Eberle St

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 1948, at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1947 to Feb 2 1948, and that I last saw him alive on Feb 1 1948.

	Duration
Immediate cause of death: Coronary Thrombosis	6 weeks
Due to: Arteriosclerosis	10 years
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury

23. Signature Joseph Pakaczy per H. W. Cain M.D. M. D.
Address 2200 E Madison St, Date signed 2-3-48

FEB 6 1948
V S 150

Huntington Williams, M.D.

X

G59792

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

G59792
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert St Cy
(c) Hospital or institution: Union Memorial Hospital 4-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 712 Chestnut Hill Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Patrick Hamill

3 (b) If veteran, name war ?

3 (c) Social Security Account No. ?

4. Sex M

5. Color or race W

6 (a) ~~Single~~ (married) ~~widowed, or divorced~~ Married

6 (b) Name of husband or wife Martha Bay Hamill

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) March 28, 1889

8. AGE: Years	Months	Days	If less than one day
58	10	6	hr. ____ min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Retired R.R. conductor

11. Industry or business Penna "

FATHER
12. Name Joseph Hamill
13. Birthplace Md

MOTHER
14. Maiden Name Ann ?
15. Birthplace ?

16 (a) Informant Hospital record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Balto
Location " Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 127 St. Paul St

19 (a) Huntington Williams, M.D. Registrar
(Date rec'd by registrar) FEB 5 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1948, at 11:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1948 to Feb 3 1948, and that I last saw him alive on Feb 3 1948.

	Duration
Immediate cause of death Uremia failure	10 days
Due to Cirrhosis of liver	3 yrs
Due to	
Other Conditions Diabetes mellitus A.H.D. fibrillata (Including conditions within 3 months of death)	3 yrs CI

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George P Thomas M.D.
Address Union Memorial Hospital Date signed Feb 3, 1948

1240

G59793

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G59793

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 17-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2627 N. Calvert Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME LOUIS KLUNK

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, ~~married, widowed, or divorced~~: Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 79 (about) | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Klunk
13. Birthplace Md.

MOTHER
14. Maiden Name Harriett Word
15. Birthplace Md.

16 (a) Informant B. Harris Henderson
(b) Address 231 St. Paul Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Jr.
(b) Address 1217 St. Paul St

19 (a) ____ (Date rec'd by registrar) (b) Williams, M.D. Registrar

FEB 5 1948

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3, 1948, at 2.25 P M

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] Medical Examiner M.D.
Date signed 2-4-48

659794

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 178a

659794 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 12-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1806 St. Paul Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alberta Eagan Fitzgerald

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband or wife: Harry Fitzgerald

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14th 1906

8. AGE: Years 41 | Months 6 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Sylvester H. Knaller
13. Birthplace Md.

MOTHER
14. Maiden Name Minnie Harris
15. Birthplace Md.

16 (a) Informant Mrs. Minnie Knaller
(b) Address 3450 - 6th St - Brooklyn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) Hunter Stevenson Williams, M.D. Registrar
FEB 5 1948

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3, 1948, at 2:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, Probable accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to Illuminating gas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 11/2

(a) Date of injury 2-3-48 at Between 12:30 & 1:30 P.M.
(b) Where did injury occur? 1315 N. Charles Street
(c) Did injury occur at home, on farm, industrial place, in public place? Apt. House While at work? No
(d) Means of injury Illuminating Gas - Gas heater out of order

23. Signature Earl L. Kruger M.D. Medical Examiner.
Date signed 2-4-48

G59795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

G59795

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 114

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Dulaney

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1314 Linden ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Anna Felix (Felix)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married

6 (b) Name of husband ~~or wife~~ Hubert C. Felix

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-25-02

8. AGE: Years 45 | Months 10 | Days 8 | If less than one day hr. min.

9. Birthplace N. Y. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Charles Thomas

13. Birthplace England

MOTHER 14. Maiden Name [illegible]

15. Birthplace N.Y.

16 (a) Informant Hubert C. Felix

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 2/6/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Meadow Ridge

Location Dorsey Md.

18 (a) Funeral director William Cook Inc.

(b) Address 217 St. Paul St

19 (a) (Date received by Registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-3-1948, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-17 1948 to 2-3 1948, and that I last saw h[illegible] alive on 2-3-1948.

Immediate cause of death Uremia — Duration

Due to Carcinoma cervix

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy Carcinoma cervix & extension

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Joseph W. Mitchell M.D.

Address Johns Hopkins Hospital Date signed 2/4/48

VS 150

FEB 5 1948

659796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

659796 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 8-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2002- E. Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jack Lucas (John Anderson Lucas)

3 (b) If veteran, name war

3 (c) Social Security Account No. 578-16-5712

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband~~ or wife Helen Lucas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16th 1886

8. AGE: Years	Months	Days	If less than one day
61	6	8	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Blacksmith

FATHER
12. Name William O. Lucas
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Whiteley
15. Birthplace Md.

16 (a) Informant Wm Lucas
(b) Address 6404 Sefton Ave.

17 (a) Burial (Burial, ~~cremation,~~ or removal) (b) Date thereof 2/7/48 (month) (day) (year)
(c) ~~Cemetery or crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St Paul st.

19 (a) Hattie Williams, M.D. Registrar
(Date rec'd by registrar) FEB 5 1948

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4, 1948 at 1.25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection ~~Autopsy~~ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Artery Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.

Date signed 2/4/48

G59797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G59797
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1003 Warden Street.
(c) Hospital or institution: 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1003 Warden Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SOPHIA V. AMEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife George C Amey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 6. 1881

8. AGE: Years	Months	Days	If less than one day
66	1	26	hr. min.

9. Birthplace Balto Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Keyser
13. Birthplace Germany

MOTHER
14. Maiden Name Lena (Unknown)
15. Birthplace France

16 (a) Informant Milton L Amey
(b) Address 2717 W. Belvedere Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Pulaski Highway

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) Huntington (b) Williams, Md (Date rec'd by registrar) Registrar
FEB 5 1948

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2, 1948, at 6 P.M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 2-3-48

G59798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G59798 ✓ X G59798

Registered No. 1176

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 Conduit St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elias R. Parker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	✓

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-20-75

8. AGE: Years	Months	Days	If less than one day
73 77	-	13	hr. min.

9. Birthplace Md
(Town, county, and State or foreign country)
10. Usual Occupation Personnel Manager
11. Industry or business Iron Foundry

FATHER
12. Name Jacob Parker
13. Birthplace Md

MOTHER
14. Maiden Name Mary Free
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Ave

18 (a) Funeral director John F. Denny Inc
(b) Address 760 Light St.

19 (a) Signature for Registrar (b) Registered FEB 5 1948
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2 1948, at 12 ± P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1947 to Feb 2 1948 and that I last saw h[illegible] alive on Feb 2 1948

Immediate cause of death Uremia — Duration 5 da.

Due to Duodenal ulcer post-operative partial gastrectomy — Duration 14 da.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1/19/48

Major findings of operation: Duodenal ulcer

of autopsy: Duodenal fistula

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry F. Bahnson
Address JHH Date signed 2/2/48

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G59799

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 19-2
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1401 Born Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Cure

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace A. A. Co. Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name unknown
13. Birthplace A. A. Co. Md.

MOTHER
14. Maiden Name unknown
15. Birthplace A. A. Co. Md.

16 (a) Informant John R. Thomas
(b) Address 1039 - Myrtle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location West Port Balto. Md.

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 927 N. Mount St.

19 FEB 5 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1948, at 9:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G. Helpbuck M.D.
Medical Examiner.
Date signed 2/1/48

VS 151

659800 fr 116011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 659800

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 47 da.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 213 N. Chapel Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Josephine Schuler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1907

8. AGE: Years	Months	Days	If less than one day
40	5	5 6	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Leonard Cullum
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Warfield
15. Birthplace Md.

16 (a) Informant Records - Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Philip Herzog Sons
(b) Address 2024 Orleans st.

19 FEB 5 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4 1948, at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 19 1947 to Feb. 4 1948, and that I last saw her alive on Feb. 4 1948.

Immediate cause of death	Duration
Urinary tract infection	
Resp Malnutrition	
Due to Chronic Alcoholism	
Other Conditions Peripheral Neuritis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. L. Sherlock Reg
Address Balto City Hosp. Date signed 2-4-48 M. D.

VS 150

BALT CUSA 1 5

G59801 BALTRUSAITIS

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G59801

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 854 West Lombard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 33

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 854 West Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kazimer Baltrusaitis

3 (b) If veteran, name war ✓

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 77 | Months 7 | Days 7 | If less than one day ___ hr. ___ min.

9. Birthplace Lithuania
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name
13. Birthplace Lithuania

MOTHER
14. Maiden Name
15. Birthplace Lithuania

16 (a) Informant Leona Liska
(b) Address 738 Portland Ave

17 (a) Burial (b) Date thereof 2-7-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Charles W. Waelzquiel
(b) Address 703 McHenry St

19 FEB 5 - 1948 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3, 1948, at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute Congestive Heart Failure

Due to Arterio-sclerotic C.V. Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 2-4-48

VS 191

059802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 059802

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere & Green Spring
(c) Hospital or institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BENJAMIN KAHN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Lena B. Kahn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 21, 1865

8. AGE: Years	Months	Days	If less than one day
82	5	15	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Hyman Kahn
13. Birthplace Russia

MOTHER
14. Maiden Name Hannah Lipmanowitz
15. Birthplace Russia

16 (a) Informant Louis Kahn
(b) Address Washington D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Baltimore, Md.

18 (a) Funeral director Bride Sondheim & Son
(b) Address 1902 Eutaw Place

19 FEB 5 1948 (Date rec'd by Registrar) (By) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-4 1948, at 6.15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1942 to 2-4 1948 and that I last saw h. l. alive on 2-4 1948.

Immediate cause of death Cerebral Thrombosis — Duration
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Henry Rapf M. D.
Address Levindale Home Date signed 2-4-48

VS 150

659803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

Registered No. 659803

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 423 N. Calhoun
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grant Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	N	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1922

8. AGE: Years	Months	Days	If less than one day
26			hr. min.

9. Birthplace Greenville, N. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Grant Brown, Sr.
13. Birthplace Greenville, N. C.

MOTHER
14. Maiden Name Nora Hunter Brown
15. Birthplace Hertford, N. C.

16 (a) Informant Nora Hunter Brown
(b) Address Hertford, N. C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 8, 1948 (month) (day) (year)
(c) Cemetery or crematory Pitt County
Location Greenville, N. C.

18 (a) Funeral director Charles H. Alexander
(b) Address 1200 McColloh St. Baltimore, Md.

FEB 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/3 1948, at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/21 1948 to 2/3 1948, and that I last saw h[illegible] alive on 2/3 1948

Immediate cause of death Carcinomatosis (Primary site - liver)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Irvin Grant

Address 1514 Division Date signed 2/5/48 M.D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G59804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Register No. G59804

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 N. CARROLLTON AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 N. Carrollton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARTHA T. FOSSETT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	COLORED	WIDOWED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1873

8. AGE: Years	Months	Days	If less than one day
75	1	2	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John Rowdens
13. Birthplace Md ?

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Md

16 (a) Informant Mr. John Mitchell
(b) Address 150 N. Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Md Trapnell & Reinsley
(b) Address 518 W. Biddle St

19 FEB 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3 1948, at 2:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-23 1947, to 1-30 1948, and that I last saw her alive on 1-30 1948.

Immediate cause of death	Duration
Arteriosclerotic Cardio-renal disease	1 year 6 mos.
Due to Generalized arteriosclerosis	1 year 6 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas W. Harris, Jr. M. D.
Address 1824 W. Franklin St Date signed 2-3-48

VS 180

G59805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

180

G59805 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14-
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 612 Smithson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Belmont Cook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: (Widowed)

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1895

8. AGE: Years 52 | Months 6 | Days 26 | If less than one day hr. min.

9. Birthplace Washington D. C. (City, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Thomas Cooks

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Berthal Brooks

15. Birthplace Washington D. C.

16 (a) Informant Mr. Thomas Cooks

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-5-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mrs. Augustus A. Hemsley

(b) Address 518 W. Biddle St.

19 (a) FEB 5 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1, 1948, at 1.10 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ or suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Extensive first-, second-, and third-degree, Burns

Due to

Pulmonary edema.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 2-1-48 at 1 a. M. 14 2

(b) Where did injury occur? 612 Smithson St. Balto. Md.

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Fire- oil stove

23. Signature George L. Merrill M.D. Medical Examiner.

Date signed 2/2/48

VS 151

G59806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G59806

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.S.A.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1028 Homewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Ditzel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7th, 1870

8. AGE: Years	Months	Days	If less than one day
77	9	26	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired Watchman

11. Industry or business Yellow Cab Co.

FATHER
12. Name Christian Ditzel
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mr. Christian Ditzel
(b) Address 1028 Homewood Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 2/7/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Lanahan Funeral Home
(b) Address 7401 Belair Road

19 (a) FEB 5 - 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/3 1948, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to Arteriosclerotic C.V Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. C. Tulumbis M.D. Medical Examiner.
Date signed 2/5/48

VS 181

659807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 659807

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6010 Clear Spring Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 8
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6010 Clear Spring Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH E. WHEELER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Nettie E. Wheeler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8th, 1881

8. AGE: Years 66 | Months 1 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Baltimore County, Md. (Town, county, and state)

10. Usual Occupation Florist

11. Industry or business

FATHER
12. Name Snowden Wheeler
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Ida Chalk
15. Birthplace Baltimore County, Md.

16 (a) Informant Mrs. J.E. Wheeler
(b) Address 6010 Clear Spring Road

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 2/6/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Lasseter Funeral Home
(b) Address 7401 Belair Road

19 (a) FEB 5 1948 (Date rec'd by Registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Feb. 3rd 1948, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1948 to Feb 3 1948 and that I last saw him alive on Feb 3 1948

Immediate cause of death	Duration
Cessation of Coronary Artery	10 days
Due to arteriosclerotic Heart Disease	1 year
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. J. Chalkatra

Address 6210 York Rd Date signed Feb 5 1948

VS 150

X

659808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 659808

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6722- Fait Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK JANCUK

3 (b) If veteran, name war: 1st World War

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Gabriela

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Laboer

11. Industry or business Columbia Specialty

FATHER 12. Name Victor Jancuk

13. Birthplace Poland

MOTHER 14. Maiden Name MICHALINA

15. Birthplace Poland

16 (a) Informant Gabriela Jancuk

(b) Address 6722 Fait ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 7-48 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus Cem

Location Balto. City

18 (a) Funeral director Wm. S. Fialkowski

(b) Address 1687 Eastern ave

19 (a) FEB 5 1948 (Date rec'd by registrar) (b) Transcription from Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3, 1948, at 7.32 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George A. Merrill M.D. (Medical Examiner.)

Date signed 2-3-48

VS 181

G59809 BC- G02518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ G59809 Registered No. 15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3380 W. CALVERT
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2mo 14days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town TOWSON
(If outside city or town limits, write RURAL and give town)
(d) Street No. 239 BURKE Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rhoda May Berlinicke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 7, 1944

8. AGE: Years	Months	Days	If less than one day
3	8	26	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Gilbert Berlinicke
13. Birthplace Balto

MOTHER
14. Maiden Name Miriam Berlinicke
15. Birthplace Balto

16 (a) Informant Gilbert Berlinicke
(b) Address 239 Burke Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 6 1948 (month) (day) (year)
(c) Cemetery or crematory Forland Memorial Park
Location Taylor Ln Park Lawn

18 (a) Funeral director John A Moran
(b) Address 3660 Baltimore Blvd

19 FEB 5 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1948, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1947 to Feb 3 1948, and that I last saw her alive on Feb 3 1948

Immediate cause of death	Duration
Status epilepticus	
Due to Epilepsy	- 3yrs
Due to Congenital ?	
Other Conditions Old depr. fracture in rt. frontal area. (Post dates epilepsy) (Include pregnancy within 3 months of death)	- 2yrs

Date of operation

Major findings of operation: Depressed frontal fracture of bone

Findings of autopsy: Terminal aspiration pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury SEIZURE

23. Signature Katherine Sprunt M. D.
Address Union Memorial Hosp. Date signed 2-4-48

VS 150

X

G59810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G59810

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23 St. Paul St
(c) Hospital or institution: Dr Beck's Sanatarium
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 da
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltocity
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2102 Maryland
(If rural give location)
(e) Citizen of foreign country? -no- (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Watson Reik

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Henry C. Reik
6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) June 5 1871

8. AGE: Years 76 | Months 7 | Days 19 | If less than one day: hr. min.

9. Birthplace Troy. New York
(Town, county, and state)

10. Usual Occupation none
11. Industry or business none

FATHER
12. Name John Watson
13. Birthplace Scotland.

MOTHER
14. Maiden Name Jane Fraser.
15 Birthplace Scotland.

16 (a) Informant Miss Esther Watson (niece)
(b) Address 2128 St Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-5-48 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn

18 (a) Funeral director Stillwell Morris Co.
(b) Address 1618 W Lanvale.

19 FEB 5 - 1948 Registered by local registrar Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1948, at 4A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1930 to Feb 3 1948 and that I last saw her alive on Feb 2 1948.

Immediate cause of death	Duration
Lymphosarcoma	11yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Nathaniel M Beck M.D.
Address 1009 Eutaw St Date signed Feb 4 48

59811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 59811

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2427 Jefferson Street
(c) Hospital or institution: 6-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2427 Jefferson Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine E. Carney

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John J. Carney
6 (c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.): June 10, 1861

8. AGE: Years: 86 | Months: 7 | Days: 23 | If less than one day: ##### hr. ##### min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: ? Michael
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name:
15. Birthplace:

16 (a) Informant: Mrs. Marie Svec (Daughter)
(b) Address: 2427 Jefferson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Road, Balto: Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) FEB 5 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 2nd 1948, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30 1948 to Feb 2 1948, and that I last saw h[illegible] alive on Feb 2 1948

Immediate cause of death	Duration
Coronary Thrombosis	Feb 2 48
Due to Chronic Myocarditis	Jan 1945
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: William J. Kyner R.
Address: 801 S. Kenwood Ave. Date signed: Feb 4 1948

X

G59812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓171a

Registered No. G59812

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3815 Falls Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MELLISSA BOWERS

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-22 87 35

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 1, 1891

8. AGE: Years	Months	Days	If less than one day
56	3	2	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Seamstress.

11. Industry or business

FATHER
12. Name John Thomas Bowers
13. Birthplace Reisterstown, Md.

MOTHER
14. Maiden Name Martha Ackens
15. Birthplace Balto.

16 (a) Informant Melissia Bowers
(b) Address 3815 Falls Road.

17 (a) Burial (b) Date thereof 2 6 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Asbury M.E. Cemetery
Location Reisterstown, Md.

18 (a) Funeral director Howard W. Blight Jr.
(b) Address 4914 Belair Road

19 (a) FEB 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3, 1948, at 5.15 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Intracranial hemorrhage
Contusion of brain.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-3-48 at 1 p.m. 12/7
(b) Where did injury occur? 38th & Cox St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian-struck by st.car.

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 2-3-48

VS 181

G59813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G59813

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1044 Patapsco St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 - 2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1044 Patapsco St

(If rural give location)

(e) Citizen of foreign country? Unc (Yes or No)

If yes, name country

3 (a) FULL NAME Sarah (Sadie) B Harig

3 (b) If veteran, name war No

3 (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Milton A Harig

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1892

8. AGE: Years	Months	Days	If less than one day
55	7	20	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Tavern owner

11. Industry or business

FATHER — 12. Name Alfred A. Edwards

13. Birthplace Balto.

MOTHER — 14. Maiden Name Hagen

15. Birthplace Balto Md

16 (a) Informant Mrs Lillian Wythelmsen

(b) Address 15 E Ostend St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 7 1948 (month) (day) (year)

(c) Cemetery or crematory Meadowridge

Location Harford Co

18 (a) Funeral director A. Howard Evans

(b) Address 4100 E Baltimore St

FEB 5 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4 1948, at 1245 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/4 1948, to 2/4 1948, and that I last saw her alive on 2/4 1948.

Immediate cause of death Acute cardiac failure due to coronary occlusion — | Duration 2 hours

Due to — |

Due to — |

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Harry Leidel M. D.

Address 1226 Hanover St Date signed 2/5/48

VS 150

659814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 659814

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 Collison Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JENNIE SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife James Henry Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18, ~~1885~~ 1871

8. AGE: Years	Months	Days	If less than one day
76 ~~62~~	10	15	hr. min.

9. Birthplace Culpepper, Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Warren Payne
13. Birthplace Virginia

MOTHER
14. Maiden Name Martha
15. Birthplace Virginia

16 (a) Informant Mabel Smith Jackson Peticola
(b) Address 219 N. Arlington Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 6 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) FEB 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2 1948 at 2:05 P M

21. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature PER: CHESTER J. LUBINSKI, M.D. M.D.
Medical Examiner.
Date signed 2-2-48

G59815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G59815

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 728 W. Mulberry St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Hawley.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 1883

8. AGE: Years 64 | Months 11 | Days ~~307~~ | If less than one day hr. min.

9. Birthplace Linco, N. C. (Town, county, and state)

10. Usual Occupation Machine Operator

11. Industry or business

MOTHER | FATHER

12. Name Robert Hawley

13. Birthplace Center Hill N. C

14. Maiden Name ? martha Gordon.

15. Birthplace Windfall, N. C.

16 (a) Informant Rebecca Bradley.

(b) Address 728 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 6 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs Katie R. Wiltgine

(b) Address 322 N. Schroeder St

19 (a) FEB 5 - 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 Feb 1948, at 5-30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 Feb 1948, to 2 Feb 1948, and that I last saw him alive on 2 Feb 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertention	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature V. A. Cacace M. D.

Franklin Square Hosp Date signed 3 Feb 48

G59816
AB- 115019

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G59816
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 18-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos
(e) Length of stay in Baltimore (yrs., mos., or days) 5yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 W. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie Lee Hubbard

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife ~

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17- 1932

8. AGE: Years	Months	Days	If less than one day
15	11	16	hr. min.

9. Birthplace Ala.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Hubbard
13. Birthplace Ala.

MOTHER
14. Maiden Name Janie Mayhan
15. Birthplace Ala.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 7, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs Katie B. Williams
(b) Address 322 N. Schroeder St.

19 (a) FEB 5- 1948 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

AM

20. DATE OF DEATH Feb. 3- 1948 at 8.15M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-5- 1947 to 2-3- 1948 and that I last saw h er alive on 2-3- 1948.

Immediate cause of death	Duration
Pulmonary Tuberculosis, Miliary type	4mo
Due to	
Due to	over
Other Conditions Pregnancy, delivered	6½mo.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Anatomic

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. E. Coleman Jr M. D.
Address Balt City Hosp Date signed 2/14/48

059817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 059817

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 755 Vine Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CORA RICE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Richard Rice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 14, 1895

8. AGE: Years	Months	Days	If less than one day
52	2	19	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Isaac Russell
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Emma Williams
15. Birthplace Baltimore, Maryland

16 (a) Informant Richard Rice
(b) Address 755 Vine Street

17 (a) Burrial (b) Date thereof Feb 7, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) FEB 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3, 1948, at 12.10 M.

21. I certify that I took charge of the remains described above, held an insp.& inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Hypertensive cardiovascular renal disease
Due to Cerebral hemorrhage, left.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl Royer M.D.
Medical Examiner
Date signed 2-3-48

VS 151

X

AdCo. 1-11 2500

G59818

HEALTH DEPARTMENT—CITY OF BALTIMORE

G59818

CERTIFICATE OF DEATH ✓ 92B

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2462 Druid Hill Ave. Ward)

Registered No.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred....yrs....mos....ds. How long in U.S. If of foreign birth?....yrs....mos....ds.

2. FULL NAME James O. Halsey

(a) Residence: No. 2462 Druid Hill Ave St., 12-3 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
male	C	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Halsey.

6. DATE OF BIRTH (month, day, year) March 11, 1900

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
47	10	22	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Tailor

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Edenington, NC

FATHER

13. NAME James Halsey

14. BIRTHPLACE (city or town) (State or country) N.C.

MOTHER

15. MAIDEN NAME Alice Jordan.

16. BIRTHPLACE (city or town) (State or country) Statesville, N.C.

17. INFORMANT Mary Halsey
(Address) 2462 Druid Hill Ave

18. BURIAL, CREMATION, OR REMOVAL
Place Int. Zion Date Feb. 5. 1948

19. UNDERTAKER Mrs Katie R. Williams
(Address) 322 N Schroeder St.

20. FILED FEB 5 - 1948 by Huntington Williams, M.D.
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Feb 2, 1948

22. I HEREBY CERTIFY, That I attended deceased from Nov 16-, 1947, to Feb, 1948
I last saw him alive on Feb-1 1948 death is said to have occurred on the date stated above, at 4.10 A.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
a. Gastric Ulcer	9
b.	
c.	
d.	
Other contributory causes of importance: Hemorrhage +	9
Mitral Insufficiency	1

Name of operation: None Date of
What test confirmed diagnosis: Clinical Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) H. Huntington Williams, M.D.
(Address) 443 South Ave

112

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

659819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No. 659819

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division St.

(c) Hospital or institution: Provident Hospital 19

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2hr 15mn

(e) Length of stay in Baltimore (yrs., mos., or days) 53

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 543 Fulton Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Isabella Berry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/10/94

8. AGE: Years	Months	Days	If less than one day
53	5	28	14 hr. min.

9. Birthplace Cambridge Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER 12. Name Thomas Kane.

13. Birthplace Cambridge Md.

MOTHER 14. Maiden Name Martha Williard

15. Birthplace Baltimore Md.

16 (a) Informant Mildred Holloway

(b) Address 543 Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 7, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St.

19 (a) FEB 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/3 1948, at 8 55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/3 1948 to 2/3 1948 and that I last saw her alive on 2/3 1948.

Immediate cause of death	Duration
Intestinal Obstruction	4 days
Due to Embryoma of Left Kidney	unknown
Due to	
Other Conditions Generalized arteriosclerosis (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy: Those mentioned above	

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature O. W. Hoffler

Address Provident Hosp. Date signed 2/4/48 M. D.

C59820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 108

Registered No. C59820

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 913 W. Lexington St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 913 W. Lexington St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alexander Burke ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Rosetta Burke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1891

8. AGE: Years 56 | Months 9 | Days | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Joseph Burke

13. Birthplace Balto. Md

MOTHER 14. Maiden Name Melia

15. Birthplace Balto. Md

16 (a) Informant James Burke

(b) Address 913 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 5 1948 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem

Location

18 (a) Funeral director Mr. Katie R. Williams

(b) Address 922 N. Schroeder St Lexington Hillsdale, Md

19 (a) FEB 5 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2 1948, at 1085 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 31 1948 to Feb 2 1948, and that I last saw him alive on Jan 31 1948.

Immediate cause of death Lobar Pneumonia — Duration about 10 days

Due to Intermuscular

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature John W. Garner M. D.

Address 507 W. Hamburg St Date signed 2/5/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

659821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓83a

Registered 659821

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 610 S Milton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 610 S Milton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martine Dombrowski

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Frances

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Frances Dombrowski
(b) Address 610 S Milton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 6 '48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 1930 Eastend Ave

19 (a) (Date rec'd by Local Registrar) (b) Thomas J. Williams, M.D.

FEB 5 1948

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1948 at 8A M

21. I certify that death occurred on the date above stated; that I attended deceased from AUG 30 1946 to FEB. 3 1948 and that I last saw h/m alive on FEB. 3 1948

Immediate cause of death	Duration
CEREBRAL DEGENERATION & ARTERIO SCLEROSIS	1945
Due to GENERALIZED ARTERIO SCLEROSIS	1945
Due to	
Other Conditions CEREBRAL HEMORRHAGE 3 YRS AGO (Include pregnancy within 3 months of death)	

Date of operation NONE

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jeff F Dorsey M. D.
Address 209 W. Center St Date signed 2/5/48

X

059822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 059822

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address LAFAYETTE AND JOHN

(c) Hospital or institution: WOMEN'S HOSPITAL 11-

(d) Length of stay in hospital or inst. (yrs., mos., or days) 50 Days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MARYLAND (b) County —

City or town BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 219 W. MADISON

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country —

3 (a) FULL NAME OLGA KATE SNYDER

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 4, 1885

8. AGE: Years	Months	Days	If less than one day
62	11	0	hr. min.

9. Birthplace LOCK HAVEN, PA. (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER

12. Name JAMES SNYDER

13. Birthplace FREMONT, PA

MOTHER

14. Maiden Name LAURA KEELER

15. Birthplace SELLINGS GROVE, PA

16 (a) Informant OLGA K SNYDER

(b) Address 219 W. MADISON

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Highland

Location Lock Haven, Pa.

18 (a) Funeral director H. W. Meader and Son

(b) Address 505 N. Balvert St.

19 FEB 5 - 1948 (Date rec'd by registrar) (b) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4 1948 at 8 55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17 1948, to Feb 4 1948, and that I last saw h[illegible] alive on Feb 1948

Immediate cause of death	Duration
Myocardial Infarction	2 Days
Due to	
Due to Hypertensive Cardiovascular Disease	+ 2 YRS
Other Conditions 2 previous infarctions. (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy: NONE

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Joel Blazer Jr M. D.

Address Woman's Hosp. Date signed 2-5-48

VS 150

X

G59823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1462

Registered No. G59823

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1519 Gilmore St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 Gilmor (If rural give location)
(e) Citizen of foreign country? ——— (Yes or No)
If yes, name country ———

3 (a) FULL NAME James E. Short
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Widower

6 (b) Name of husband or wife Pauline
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 10, 1887

8. AGE: Years	Months	Days	If less than one day
60	8	24	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name Edward Short
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Jane Pyle
15. Birthplace Md.

16 (a) Informant Catherine Williams
(b) Address 1519 Gilmore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 6 48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location

18 (a) Funeral director Mrs. R. H. Elliott & Daughter
(b) Address 1129 N. Caroline St.

19 (a) Feb 5 1948 (Date received by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1948 at 3:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-18-1948 to 2-3-1948 and that I last saw him alive on 2-1-1948.

Immediate cause of death Cardiac Failure and Gastric Carcinoma

Duration

Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation ———
Major findings of operation: ———
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. Boyking M.D.
Address 1133 Monroe Date signed 2-5-48

VS 3

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G59824

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eutaw Place & Brooks Lane. Esplanade Apts.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Temple Garden Apts.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS KATZ.

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-03-0044.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Bertha K. Katz.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1876.

8. AGE: Years	Months	Days	If less than one day
71	4	18	hr. min.

9. Birthplace Germany. (Town, county, and state)
10. Usual Occupation Jeweler.
11. Industry or business

FATHER
12. Name Baruch Katz,
13. Birthplace Germany.

MOTHER
14. Maiden Name Zerlina Nordhiser.
15. Birthplace Germany.

16 (a) Informant Mrs. Harold Newman.
(b) Address Temple Garden Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2.6.48. (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom
Location Balto. Md.

18 (a) Funeral director Harris Levinson Chapel
(b) Address 1908 Eutaw Place.

19 (a) FEB 5 - 1948 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4th. 1948, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1948 to Feb 4 1948, and that I last saw h[illegible] alive on Feb. 4 1948.

Immediate cause of death	Duration
Coronary Thrombosis	1 hour
Due to Coronary Sclerosis	2-5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Esplanade Apts. Date signed 2/5/48 M D

VS 150

X

Hughes

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310

Register (No.) 59825

59825

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2024 Druid Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2024 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Columbia Hughes

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	Colored	Widow

6 (b) Name of husband or wife Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1857

8. AGE: Years	Months	Days	If less than one day: hr.	min.
90	4	19		

9. Birthplace West Point, Va (Town, county, and state)

10. Usual Occupation Housemaid

11. Industry or business

FATHER
12. Name ? Johnson
13. Birthplace Va

MOTHER
14. Maiden Name Mary ? ?
15. Birthplace Va

16 (a) Informant Mr. Howard Hughes
(b) Address 2024 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-5-1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Lew H. Holland
(b) Address 1621 Druid Hill Ave

19 (a) FEB 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-3 1948, at 12 55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1948 to Feb 3 1948 and that I last saw her alive on Feb 1948.

Immediate cause of death	Duration
Myocarditis	6 weeks
Due to Arteriosclerosis	4 years
Due to	
Other Conditions none	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George McDonald M.D.
Address 844 W Carey St Date signed 2/5/48

VS 150

G59826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. G59826

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2122 E. Hoffman St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert H. White

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Beulah

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) 9-27-74

8. AGE: Years 73 | Months 4 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John White
13. Birthplace Md

MOTHER
14. Maiden Name Emma Amick
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Dist. Apt.

18 (a) Funeral director John E. Miller Jr.
(b) Address 2435 E. Oliver St

19 FEB 5 - 1948 (Date rec'd by registrar) (b) Washington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3 1948, at 10 M 45 A

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 3 1948 to Feb 3 1948, and that I last saw him alive on Feb 3 1948.

Immediate cause of death CARDIAC FAILURE — Duration 48 HRS

Due to PULMONARY EMBOLISM — Duration 48 HRS

Due to RESECTION OF CARCINOMA OF LUNG — Duration ?

Other Conditions EMPYEMA

(Include pregnancy within 3 months of death)

Date of operation MAR 7 1948

Major findings of operation: CARCINOMA OF LUNG

If autopsy: PULMONARY EMBOLUS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard C. Clay M. D.
Address Johns Hopkins Hosp Date signed 2-5-48

VS 150

G59827

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

Registered No. G59827

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1338 No. Carey
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Selina Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife Millard Parker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/12/1883

8. AGE: Years	Months	Days	If less than one day
62	1	27	- hr. - min.

9. Birthplace md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James Gray
13. Birthplace md

MOTHER
14. Maiden Name Minnie Hawkins
15. Birthplace md

16 (a) Informant David Jones
(b) Address 1338 N Carey St

17 (a) Burial (b) Date thereof 2/8/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cooper's Chapel
Location Calvert Co. Md.

18 (a) Funeral director Geo. G. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) FEB 5 - 1948 (b) Huntingtown, Williams, Md.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3, 1948, at 9:55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1948 to Feb 3, 1948, and that I last saw her alive on Feb 3, 1948.

Immediate cause of death	Duration
Cerebral vascular accident	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ben Bolle M. D.
Address Univ. Hosp. Date signed 2-5-48

VS 159

G59828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No. G59828

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1031 N. Carey (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dennis Smallwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	N	Married

6 (b) Name of husband or wife Zeta
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
56 yrs			hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Haley Smallwood
13. Birthplace Md

MOTHER
14. Maiden Name Jane Hawkins
15. Birthplace Md

16 (a) Informant Zeta Smallwood
(b) Address 1031 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md

18 (a) Funeral director Wm. H. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) Date received by registrar 1948 (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/3 1948 at 10:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/3 1948 to 2/3 1948 and that I last saw h[illegible] alive on 2/3 1948

Immediate cause of death: Subarachnoid Hem- a-- hage — Duration

Due to Hypertension — 2-3 6-a..

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Porter Shutt M D

Address 1514 Division Date signed 2/4/48

G59829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G59829 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1319 Park Avenue
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 74 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 17 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1319 Park Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Anne Franklin Hall

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~or wife~~ Sidney Hall
6 (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) June 21, 1867

8. AGE: Years	Months	Days	If less than one day
80	7	13	12 hr. min.

9. Birthplace Perrymans Harford Co. Md. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business —

FATHER
12. Name Savington Warren Crampton
13. Birthplace Frederick Co. Maryland.

MOTHER
14. Maiden Name Anne Isabella Perryman
15. Birthplace Perrymans, Harford Co. Md.

16 (a) Informant Sidney Hall
(b) Address 1319 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 6 1948 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Specutia Church
Location Perrymans Harford Co. Md.

18 (a) Funeral director Henry W. Jenkins & Sons
(b) Address McCulloh & orchard Streets

19 (d) FEB 5 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3 1948, at 11.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1948, to Feb 3 1948, and that I last saw h~~er~~ alive on Feb 1 1948.

Immediate cause of death	Duration
Immediate Pneumonia	2 days.
Due to Cardio Renal Vascular Disease	6 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H K Delaney M D M. D.
Address Aberdeen Md Date signed Feb 4, 1948

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G59830

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 27-16 D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3415- St. Ambrose Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis M. Ruddy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Mary E. Ruddy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27, 1884

8. AGE: Years	Months	Days	If less than one day
64	0	7	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Maritime Police,
11. Industry or business

FATHER
12. Name Austin Ruddy,
13. Birthplace Ireland,

MOTHER
14. Maiden Name Ellen Martin,
15. Birthplace Ireland

16 (a) Informant Mrs. Mary E. Ruddy,
(b) Address 3415 St. Ambrose Ave.,

17 (a) burial (b) Date thereof 2/7/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore City,

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) FEB 5 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4, 1948, at 10.30 A M

21. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive Cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 2/4/48

VS 151

X

G59831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G59831

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene Sts.

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 15 49

(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)

(d) Street No. 4010 Alto Rd. (If rural give location)

(e) Citizen of foreign country? -- (Yes or No) If yes, name country --

3 (a) **FULL NAME** Summers, Charles D.

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex M

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Elizebeth Gaither Summers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jun. 11, 1870

8. AGE: Years 77 | Months 7 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Trappe, Md. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Self

MOTHER / FATHER

12. Name Samoul Summers

13. Birthplace Md.

14. Maiden Name Anna Louisa Ross

15. Birthplace Md.

16 (a) Informant Margaret R. Summers

(b) Address 4010 Alto Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/48 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Loudon Park

Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.

(b) Address North & Pa. Aves; Balto., Md.

19 (a) FEB 5 - 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 1948, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1948, to Feb 4 1948, that I last saw h-- alive on Feb 4 1948.

Immediate cause of death Cerebral hemorrhage, left ext. hemiplegia — Duration

Due to Hypertensive cardio-vascular disease

Due to

Other Conditions Comminuted fracture R. anterior fossa of skull, following fall

(Include pregnancy within 3 months of death)

Date of operation cerebral hemorrhage.

Major findings of operation: was not performed

of autopsy:

PHYSICIAN: Underline the cause to which death is due primarily.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible]

Address Univ. Hosp. Date signed 2/6/48

659832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164c

Registered No. 659832

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3/4 hour
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Cockeysville
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine M. McCaffray

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	Yes

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	Married

6 (b) Name of husband or wife Edmond McCaffrey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jun. 21, 1918

8. AGE: Years	Months	Days	If less than one day
29	7	13	hr. min.

9. Birthplace Wash. D.C.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Williamson Veneer Co.

FATHER
12. Name E. Kennerly Marshall
13. Birthplace Charleston, S.C.

MOTHER
14. Maiden Name Berry Carroll
15. Birthplace Columbus, Ohio

16 (a) Informant Mr. Edmund McCaffray Jr.
(b) Address Paper Mill Rd., Cockesville, Md.

17 (a) Cremation (b) Date thereof 2/5/48
(Burial, cremation, or removal) (month) (day) (year)
(c) ~~Cemetery~~ or crematory Greenmount Crematory
Location Bal timore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address Baltimore, Md.

19 (a) FEB 5 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4th 1948, at 8 45 P M

21. I certify that I took charge of the remains described above, held an Autopsy & Inquest thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gun shot wound head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Feb 4th 1948 M
(b) Where did injury occur? Cockeysville, Md
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Shot self in roof of mouth.

23. Signature William J. Kelbel M.D.
Medical Examiner.
Date signed Feb 5 1948

VS 151

PRESS WHITE PANEL WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C59833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. C59833

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4910 Reisterstown Rd
(c) Hospital or institution: 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) ---

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4910 Reisterstown Rd. (If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME CHARLES FREDERICK MICHEL

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	212-22-9670

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Margaret E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 28, 1881

8. AGE: Years	Months	Days	If less than one day
67	0	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Plumber-- Retired
11. Industry or business --

FATHER
12. Name Charles F. Michel
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma (Unknown)
15. Birthplace Maryland

16 (a) Informant Margaret E. Michel
(b) Address 4910 Reisterstown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Loudon Park
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves; Balto., Md.

19 (a) FEB 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Feb. 3, 1948 19 at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 19 45 to Feb 3 19 48 and that I last saw h[illegible] alive on Feb 3 19 48.

Immediate cause of death	Duration
Coronary Thrombosis	3 days
Due to	
Due to	
Other Conditions Septic decubitus	8 years

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Manuel Levin M. D.
Address 488 Reisterstown Rd Date signed 2/4/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 150

X

G59834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

Registered No. G59834

Please answer questions 1 to 19 and 22 to 24 completely. Information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 W. Rogers Ave. 27
(c) Hospital or institution: Home For the Aged of the Methodist Church
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 72 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 W. Rogers Ave.
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME MARTHA M. KEMP

3 (b) If veteran, name war: **
3 (c) Social Security Account No. ---

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Sameul R. Kemp
6 (c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.) Sept. 12, 1860
8. AGE: Years 87 | Months 4 | Days 21 | If less than one day ____ hr. ____ min.
9. Birthplace Balto. County, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business --

FATHER
12. Name Benjamin Foord
13. Birthplace Balto. County, Md.

MOTHER
14. Maiden Name Mary Forward
15. Birthplace Harford Co., Md.

16 (a) Informant Mariam O. Coates-- Supt.
(b) Address 2211 W. Rogers Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/48 (month) (day) (year)
(c) Cemetery or ~~xxxxxx~~ Lorraine
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address North & Pa. Aves., Balto., Md.
Huntington Williams, M.D.

19 FEB 5 1948 (Date rec'd by registrar) (b) 8 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3, 1948 19__, at 4:40P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1948 to Feb 2 1948 and that I last saw h__ alive on Feb 2 1948.

	Duration
Immediate cause of death: Carcinoma of ~~Stomach~~ Liver	6 Months
Due to:	
Due to:	
Other Conditions: (Include pregnancy within 3 months of death)	
Date of operation:	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur J. Davies M. D.
Address 800 W 32nd St Date signed 2-4-48

VS 159

G59835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 13

Registered No. G59835

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3204 Westwood Ave.
(c) Hospital or institution: --
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3204 Westwood Ave.
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME THOMAS J. MITCHELL

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Rowena G.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 7, 1848 (?)

8. AGE: Years 76 | Months 10 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business B&O RR

FATHER
12. Name THomas W. Mitchel
13. Birthplace Maryland

MOTHER
14. Maiden Name -- ----- Wolf
15. Birthplace Md.

16 (a) Informant Mrs. Rowena G. Mitchel
(b) Address 3204 Westwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/48 (month) (day) (year)
(c) Cemetery or crematory XXXXX Lorraine
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves., Balto; Md.

19 (a) FEB 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/3/48 19..., at 5:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 to Feb 3 1948 and that I last saw him alive on Feb 3 1948.

Immediate cause of death Hole in Lungs & Bones

Duration: for a few years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]

Address 3330 Westwood Ave. Date signed 3/4/48 M. D.

VS 152

X

659836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 97

Registered No. 659836

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27. N. Carey St.
(c) Hospital or institution:
Good Samaritan Nursing Home. 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) --

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 E. Lafayette St.
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME ANNIE M. KING

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	No	F	W	Married

6 (b) Name of husband or wife Thomas J. King
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1877

8. AGE: Years	Months	Days	If less than one day
70	5	5	hr. min.

9. Birthplace Ireland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business --

FATHER
12. Name John Leary
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizebeth Curra n
15. Birthplace Ireland

16 (a) Informant Mrs. Wm. P. Mona han--Sister
(b) Address 1807 Aiken St.

17 (a) Burial (b) Date thereof 2/6/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ New Cathedral
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address North & Pa. Aves; Balto., Md.

19 (a) FEB 5 - 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1948, at 6.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 1947 to Feb 3 1948, and that I last saw h~~e~~r alive on Feb 3 1948

Immediate cause of death	Duration
Acute Congestion	
Due to Fibroid Hypertension	
Due to Cerebral Hemorrhage	
Other Conditions Oedema	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos Cunningham M. D.
Address 27 N Carey Date signed 2/3/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G59837

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 811 Venable Ave.
(c) Hospital or institution: --
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) --

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 811 Venable Ave.
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME SOPHIA C. WALLBILLICK

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	No	F	W	Widowed

6 (b) Name of husband or wife Jacob Wallbillick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 13, 1868

8. AGE: Years	Months	Days	If less than one day
80	0	20	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jacob Fohner
13. Birthplace Germany

MOTHER
14. Maiden Name Anna C. Gorky
15 Birthplace Germany

16 (a) Informant Miss May H. Wallbillick
(b) Address 811 Venable Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Loudon Park
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address Baltimore, Md.

19 (a) FEB 5 - 1948 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3, 1948 19..., at 12 03 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1946 Feb 3 1948 and that I last saw h[er] alive on Feb 3 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	Jan 3 48
Due to Generalized Arteriosclerosis	Jan. 1 1946
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Rosser M. D.
Address 801 Kelwood Ave. Date signed 2/4/48

G59838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164a

Registered No. G59838

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16-8
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3807 Colbourne Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: LESLIE O. McCLOSKEY

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No. Yes

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Hilda C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1901

8. AGE: Years 46 | Months 2 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Furniture Salesman

11. Industry or business

FATHER
12. Name Arrin McCloskey
13. Birthplace Penna.

MOTHER
14. Maiden Name Maude Edmonston
15. Birthplace Baltimore, Md.

16 (a) Informant Hilda C. McCloskey
(b) Address 3807 Colbourne Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address Northern Pa. Aves; Balto., Md.

19 (a) FEB 5 1948 (Date rec'd by registrar) (by) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3, 1948, at 8.17 AM

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Hanging

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-3-48 at about 6.50 a. M.
(b) Where did injury occur? 3807 Colbourne Road. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Hung himself with sash cord from joist -basement.

23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed 2-3-48

VS 191

X

659839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

659839 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Balto General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 74 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 16 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3411 Fairview Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN WILLIAM IMHOFE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary G. Imhofe
6 (c) If dead, give age 74 years

7. Birth date of deceased (mo., day, yr.) Nov 19, 1873

8. AGE: Years	Months	Days	If less than one day
74	2	15	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation retired -- Post Office
11. Industry or business

FATHER
12. Name Herman Imhofe
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Pierker
15. Birthplace Baltimore Md.

16 (a) Informant wife
(b) Address 3411 Fairview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/48 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Woodlawn
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves; Balto., Md.

19 (a) FEB 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 1948, at 12:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1948 to Feb 4 1948 and that I last saw him alive on Feb 4 1948

Immediate cause of death	Duration
Acute pulmonary edema and cerebral hemorrhage	
Due to Hypertensive cardio vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Hilton M. D.
Address South Balto Gen Hosp Date signed 2-9-48

VS 150

G59840

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a

Registered No. G59840

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1907 N. Fulton Ave D.O.A.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1907 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth R. Bensel

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1866

8. AGE: Years	Months	Days	If less than one day
81	4	11	21 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Conrad Bensel
13. Birthplace Europe

MOTHER
14. Maiden Name Elizebeth D. Amend
15. Birthplace Europe

16 (a) Informant Mrs. W. E. Ruppel
(b) Address 1907 N. Fulton Ave.

17 (a) Burial (b) Date thereof Feb. 7, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~xxxxxxx~~ St. Paul Reformed Chr.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Ave; Balto., Md.

19 (a) FEB 5 - 1948 (b) Huntington-Williams, Inc.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/7 19 48, at 3 40 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive - Arteriosclerotic Cardio - Renal Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 2/7/48

VS 191

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

Registered No. G59841

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Watkins + Catonsville Aves.
(c) Hospital or institution: St. Agnes Hospital 2bed
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 527 S Newkirk St. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country Greece

3 (a) FULL NAME Michael Lindos (Mike)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Wife - Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 - - 1887

8. AGE: Years	Months	Days	If less than one day
58 [redacted]			hr. min.

9. Birthplace [redacted] Greece (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Christopher (Dec.)
13. Birthplace Greece

MOTHER
14. Maiden Name Mary (Dec.)
15. Birthplace Greece

16 (a) Informant Son
(b) Address 527 S. Newkirk St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-48 (month) (day) (year)
(c) Cemetery or crematory Greek Cem
Location Woodlawn Mill Rd.

18 (a) Funeral director Lambros Funeral
(b) Address 440 E. North Ave Md.

FEB 5 1948 (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3 1948 at 8:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1 1948 to 2-3 1948 and that I last saw him alive on 2-3 1948

Immediate cause of death Cerebral Thrombosis (Basilar Artery) — Duration

Due to Generalized arteriosclerosis

Due to

Other Conditions Lobular pneumonia (terminal) (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy? Same as above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Anthony J. Venable Jr. M.D. M.D.
Address St. Agnes Hospital Date signed 2-3-48

VS 150

X

659842

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1100

Registered No. 659842

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hosp 20 Hours
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2134 Wilkens Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Koplowitz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Married

6 (b) Name of husband or wife Pauline
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired Tailor
11. Industry or business

FATHER
12. Name Benjamin
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Pauline Koplowitz
(b) Address 2134 Wilkens Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-48 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Boulevard

18 (a) Funeral director Jacob Levin Inc
(b) Address 2160 Eutaw Place

FEB 5 - 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1948, at 1:17 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1948 to Feb 5 1948 and that I last saw h[illegible] alive on Feb 5 1948.

Immediate cause of death Septicemia

Due to Metastatic bacterial infection from furuncle on Rt. thigh

Due to

Other Conditions Emphysema, Arteriosclerosis, Old Lung Infarct, Old Lung

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence Jr MD
Address Univ. Hosp Date signed 2/5/48

VS 150

FILLING WITH CARE, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

59843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1224

Registered No. 59843

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST
(c) Hospital or institution: ST JOSEPHS HOSP
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days) 88 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5008 YORK RD (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME O'CONNOR ELIZ. Magdalene

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife TIMOTHY J. O'CONNOR
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 11/11/1859

8. AGE: Years	Months	Days	If less than one day
88	2	22	____ hr. ____ min.

9. Birthplace BALTO, MD (Town, county, and state)
10. Usual Occupation AT HOME
11. Industry or business

FATHER
12. Name Louis Gilbert
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MAGDALENE BRUNCK
15. Birthplace MARYLAND

16 (a) Informant L. ELLWOOD O'CONNOR
(b) Address 5306 NORWOOD AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof FEB 6-48 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location Old Frederick Rd

18 (a) Funeral director CHAS. F. EVANS & SON
(b) Address 148 W. Mt Royal Ave

19 (a) FEB 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/3 1948 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/12 1948 to 2/3 1948, and that I last saw her alive on 2/3 1948.

Immediate cause of death	Duration
RESP. FAILURE	
~~PULMONARY EMBOLUS~~	
Due to PULMINARY EMBOLUS	
Due to	
Other Conditions FECAL FISTULA	

(Include pregnancy within 3 months of death)
Date of operation 1/24/48
Major findings of operation: STRANGULATED VENTRAL HERNIA
of autopsy: NO

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry P. Parker M. D.
Address St. Jos. Hosp. Date signed 2/3/48

V S 150

G59844 H.L.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G59844

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospital 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1102 Wilcox St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Agness Bessie Freshline

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1875

8. AGE: Years	Months	Days	If less than one day
72	11	19	hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business at Home

FATHER
12. Name Barthamew Queenan
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Ford
15. Birthplace Ireland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 7, 1948 (month) (day) (year)

(c) Cemetery or crematory Mount Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director E. W. Conkling & Son
(b) Address 2246 E. Eager St.

19 (a) FEB 5 - 1948 (Date rec'd by registrar) (b) Interior for Nuttawa, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4 1948, 10.55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 11 1947 to Feb. 4 1948 and that I last saw h er alive on Feb. 4 1948.

Immediate cause of death Broncho-pneumonia — Duration 3 days

Due to

Due to

Other Conditions neck fracture of femur — 2 mos

(Include pregnancy within 3 months of death)

Date of operation 12/11/47

Major findings of operation: Fx of femur

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 10/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 12/10/47 at 2 P. M.
(c) Where did injury occur? Balt. (City or town) Balt. (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury Fall on icy walk

23. Signature Gordon Craft M. D.
Address Balt. City Hosp. Date signed 2-4-48

To be approved by Medical Examiner for Dr. J. Weinberg by J. Mancini, M. D.

VS 150

G59845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G59845

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2130 Cambridge St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)

(d) Street No. 2130. Cambridge St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EMMA TAYLOR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Richard H. Taylor

6 (c) If alive, give age Yes years

7. Birth date of deceased (mo., day, yr.) Sept. 27. 1906

8. AGE: Years	Months	Days	If less than one day
47.	4.	8.	hr. min.

9. Birthplace Ash. North Carolina (Town, county, and state)

10. Usual Occupation HOUSE WIFE,

11. Industry or business

FATHER

12. Name John W. CLARK.

13. Birthplace North Carolina

MOTHER

14. Maiden Name Wynnon

15 Birthplace North Carolina

16 (a) Informant Mary Nathaniel

(b) Address 2130 Cambridge St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 6. 1948 (month) (day) (year)

(c) Cemetery or crematory OAK LAWN.

Location Eastern ave. Road.

18 (a) Funeral director WENDELL J. DIPPEL

(b) Address 313 S. HIGHLAND Ave

19 (a) FEB 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 3 19 48, at 10 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1945 to Feb 3 1948, and that I last saw h alive on Feb 3 1948.

Immediate cause of death Carcinoma of Rectum

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1945

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Milton L. Solomon

Address 129 S. Bway Date signed 2/5/48

VS 150

G59846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G59846

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 719 Harlem Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 719 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fletcher Curtis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Jennie Fletcher

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1878

8. AGE: Years: 69 | Months: 8 | Days: 1 | If less than one day: hr. min.

9. Birthplace Parsley Virginia
(Town, county, and state)

10. Usual Occupation Ice, Coal, Wood Dealer

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Laura Curtis
15. Birthplace Parsley, Va.

16 (a) Informant Nettie J. Foster
(b) Address 719 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 5 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 3229 W. Lexington St.

19 (a) FEB 5 - 1948 (Date rec'd by registrar) Harrington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2 1948 at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28 1948 to Feb 2 1948. and that I last saw h[illegible] alive on Feb 2 1948

Immediate cause of death: Coronary Thrombosis — Duration: 7 hrs.

Due to: Arterio-sclerosis — Duration: 9 yrs.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles T. Woodland

Address 861 Harlem Ave Date signed Feb 6/48

Chas T. Woodland

G59847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1579

G59847 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Calvert
(c) City or town Huntingtown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Page C. Watson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-30-48

8. AGE: Years | Months | Days: 5 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Stanley Watson
13. Birthplace Md.

MOTHER 14. Maiden Name Mary Bowen
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 6, 1948 (month) (day) (year)
(c) Cemetery or crematory Calvary
Location Huntingtown, Md

18 (a) Funeral director O. O. Harkins & Son
(b) Address Mutual, Md

19 (a) FEB 5 - 1948 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-4-48, 19, at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-2-48, 19, to 2-4-48, 19, and that I last saw h alive on 2-4-48, 19.

Immediate cause of death Circulatory failure - peripheral — Duration 4 hrs.
Due to Intestinal Obstruction
Due to Imperforate anus with Recto vesicle fistula — 5 days
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 2-3-48
Major findings of operation: Intestinal Obstruction - Atresia of rectum
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Crigler, Jr. M.D.
Address The Johns Hopkins Hosp signed 2-5-48

VS 150

G59848

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

54a

G59848
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fremont Redwood St
(c) Hospital or institution:
University Hosp.
(d) ~~Length~~ of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Dorchester
(c) City or town Cambridge Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 247 Race St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Priscilla Conway

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) ~~Single~~, married, ~~widowed~~, or divorced: married
6 (b) Name of husband or ~~wife~~ James Gardam
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 6-23-24
8. AGE: Years 23 | Months 7 | Days 12 | If less than one day hr. min.
9. Birthplace Va
(Town, county, and state)
10. Usual Occupation Housedworker
11. Industry or business

FATHER
12. Name Joseph Collins
13. Birthplace Md

MOTHER
14. Maiden Name Eva Jones
15. Birthplace Md

16 (a) Informant University Hosp
(b) Address

17 (a) Buried (b) Date thereof 2/8/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Dorchester Memorial Park
Location Cambridge, Md

18 (a) Funeral director John O' Mitchell Sons
(b) Address 1900 Eutaw Place

19 FEB 5 - 1948
(Date rec'd by registrar) Huntington Williams M.D.

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 1948 at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/24 1947 to 2/5 1948 and that I last saw her alive on February 5 1948.

Immediate cause of death	Duration
Respiratory Failure	
Due to Medullary Depression	
Due to Uremia [redacted] Paralysis Legion	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11/6/47
Major findings of operation: [redacted] Paralysis Legion
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank Greenbank M.D.
Address University Hosp. Date signed 2/5/48

X

G59849

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G59849 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Athol Ave. 28-4
(c) Hospital or institution:
General German Aged People Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. Athol Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Gross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18, 1875

8. AGE: Years	Months	Days	If less than one day
72.	7	15	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Conrad Gross

13. Birthplace Germany

MOTHER 14. Maiden Name Marie Stemler

15. Birthplace Germany

16 (a) Informant Mrs. J. Geo. Walz Sister

(b) Address 22 S. Athol ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 6/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk

Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Tuttle

(b) Address 4101 Edmondson ave

19 (a) (Date rec'd by registrar) (b) Washington Williams Mull Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3/48 19 at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 20/48 to Feb. 3/48 19 and that I last saw h alive on Feb. 3/48 19

Immediate cause of death	Duration
Coronary Thrombosis Unknown	
Due to	
Due to	
Other Conditions	
Chronic Cardiac Hypertrophy (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Wade Chesney M. D.

Address 23 Hanover Date signed Feb 6/48

FEB 5 1948

X

G59850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G59850

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3719 Hillsdale Road
(c) Hospital or institution: 28-1
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3719 Hillsdale Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lottie Virginia (Jennie) Luttgerding

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 21, 1862

8. AGE: Years	Months	Days	If less than one day
85	2	12	hr. min.

9. Birthplace Granite, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Henry C. Luttgerding
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Ann Hayworth
15. Birthplace Ellicott City, Md.

16 (a) Informant Mrs. John C. Beck
(b) Address 370 Old Garden Lane, York, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 5, 1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18 (a) Funeral director Wilbur Amonas
(b) Address 4510 Liberty Heights Ave.

19 (a) Feb 6 - 1948 (Date rec'd by Registrar) (b) Huntington Williams, Registrar, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3 1948, at 3.37 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 11 1938 to Feb 3 1948, and that I last saw her alive on Feb 1 1948.

Immediate cause of death	Duration
Cerebral Thrombosis	1 hr
Due to Cerebral Arteriosclerosis	10 yrs
Due to	
Other Conditions Chronic Endocarditis Chronic Myocarditis —	5 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 3403 Garrison Blvd. Date signed

VS 150

G59851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G59851 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3210 Howard Park Ave.
(c) Hospital or institution: 28.2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3210 Howard Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Samuel Walter Sparks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Idella Frances Sparks
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) September 8, 1878

8. AGE: Years	Months	Days	If less than one day
69	5 4	26	hr. min.

9. Birthplace Crumpton, Queen Anne Co., Md.
(Town, county, and state)
10. Usual Occupation Retired School Teacher
11. Industry or business

FATHER
12. Name Samuel E. Sparks
13. Birthplace Queen Anne County, Md.

MOTHER
14. Maiden Name Augusta Emerson
15. Birthplace Queen Anne County, Md.

16 (a) Informant Mrs. Samuel Walter Sparks
(b) Address 3210 Howard Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 6, 1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Miller & Amonas
(b) Address 4610 Liberty Heights Ave.

19 (a) FEB 6 - 1948 (This is record by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 1948, at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 23 1947 to Feb 4 1948 and that I last saw him alive on Feb. 3 1948.

	Duration
Immediate cause of death Myocarditis	4 months (a)
Due to Advanced arterio-sclerosis	?
Due to	
Other Conditions Hypertension	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hallie Tuttle M. D.
Address 2220 Garrison Blvd. Date signed

VS 150

59852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 0559852

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4515 Garrison Blvd.
(c) Hospital or institution: Haven Nursing Home 15-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3401 Fairview Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Fountain

3 (b) If veteran, name war

3 (c) Social Security Account No. 577-03-3730

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nana M. Fountain
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) October 20, 1887

8. AGE: Years	Months	Days	If less than one day
60	3	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Men's Clothing

FATHER
12. Name Samuel Fountain
13. Birthplace Caroline County, Md.

MOTHER
14. Maiden Name Mary Elizabeth Robertson
15. Birthplace Newbern, N. C.

16 (a) Informant Mrs. Nana M. Fountain
(b) Address 3401 Fairview Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 7, 1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Miller Lamprecht
(b) Address 4810 Liberty Heights Ave.

19 (a) FEB 6 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 1948, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1941, to Feb 4 1948 and that I last saw him alive on Jan 30 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	Immediate
Due to Arterio sclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. Walter Spurrier M.D.
Address 3603 Edmondson Ave. Date signed 2/5/48 M. D.

Spurrier X

59853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G59853 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3625 Manchester Ave
(c) Hospital or institution: 27-18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3625 Manchester Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laura J. Coleman
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	W.

6 (b) Name of husband or wife Samuel J.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 16 1859

8. AGE: Years	Months	Days	If less than one day
88	1	19	hr. min.

9. Birthplace Orange Co. Va. (town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name Acie Massey
13. Birthplace Va.

MOTHER
14. Maiden Name Sallie Swift
15. Birthplace Va

16 (a) Informant Mrs John Wagner
(b) Address 3625 Manchester Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-48 (month) (day) (year)
(c) Cemetery or crematory Shepherds Rest Baptist Church
Location Rhodesville, Va.
18 (a) Funeral director Spring Byers
(b) Address 5005 North Charles
19 FEB 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4, 1948, at 7:25 M
21. I certify that death occurred on the date above stated; that I attended deceased from 2/2 1948 to 2/4 1948, and that I last saw h. alive on 2/4 1948.

Immediate cause of death	Duration
Apoplexy	1 day
Due to Cerebral Sclerosis	days
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature? H. B. Huntington Williams M.D.
Address 1901 Eutaw Pl Date signed 2/7/48

V S 150

C59854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. C59854

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 S. Patterson Pk (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen V. Foard

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Chas. T. Foard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-18-0[illegible]

8. AGE: Years 43 | Months 4 | Days 16 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Packer

11. Industry or business Cheroket Plant

FATHER
12. Name Peter Lienaus
13. Birthplace Germany

MOTHER
14. Maiden Name Christ[illegible]
15. Birthplace Germany

16 (a) Informant Chas. T. Foard Jr. and
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (b) Registrar

FEB 6 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-4-48 19 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-2-48 19 to 2-4-48 19, and that I last saw h[illegible] alive on 2-4-48 19

Immediate cause of death Pneumonia and Pulmonary Infarction — Duration 1 week

Due to Rheumatic Heart Disease

Due to

Other Conditions Cardiac failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Grob M. D.
Address JNH Date signed 5-Feb 48

V5-750

G59855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

G59855 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 W. Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Etta Fraizie

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex Female | **5. Color or race** White | **6 (a) ~~Single, married~~, widowed, or ~~divorced~~** Widowed

6 (b) Name of husband ~~or wife~~ Lawrence Fraizie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 7th 1866

8. AGE: Years 81 | Months 3 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Centreville Md
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Solomon Barrett
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary E. Floyd
15. Birthplace Unknown

16 (a) Informant Chas. M. Connor
(b) Address 2112 Kentucky Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) **(b) Date thereof** 2/6/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) ~~Filed by~~ ~~(Signature)~~ ~~(Address)~~

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4th 1948, at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28 1948 to Feb 4 1948 and that I last saw her alive on Feb 3 1948.

Immediate cause of death Cardiac failure ... **Duration**
Due to Chronic Myocarditis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Seagmuller M. D.
Address 1724 N Longland St Date signed 2/4/48

X

G59856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G59856 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1507 Park Ave
(c) Hospital or institution:
14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace M Coulter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married

6 (b) Name of husband ~~or wife~~ C Harold Coulter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 3rd 1874

8. AGE: Years 73 | Months 4 | Days 2 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name L. Jeff Milbourne
13. Birthplace Shelltown Md.

MOTHER
14. Maiden Name Margaret McGee
15. Birthplace Balto. Md.

16 (a) Informant C. Harold Coulter
(b) Address 1507 Park Ave.

17 (a) Burial (b) Date thereof 2/7/48
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Woodlawn
Location md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) ~~Filed~~ [illegible] Thurlington Williams M.D.
(Date received) FEB 6 1948 (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5th 1948, at 2:55 P.M.

21. I certify that I took charge of the remains described above, held an Aug Ed Insp thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Feb death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma of Breast

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Thurlington Williams M.D.
Medical Examiner.
Date signed 2-5-48

VS 151 c

X

Please answer all questions. Write in ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937 G59857

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D/A
(c) Hospital or institution: Mercy Hospital H-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 209 W. Saratoga St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ADLINE H. (Adelaide) Silber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~.
F	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years	Months	Days	If less than one day
83			hr. min.

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name S. Hauptman
13. Birthplace

MOTHER
14. Maiden Name Rozokel
15. Birthplace

16 (a) Informant Pell Van Dine
(b) Address 232 Smith st. Woodmere, L.I.

17 (a) Removal (b) Date thereof 2/7/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location New York City

18 (a) Funeral director William Cobb Inc.
(b) Address 1217 St. Paul st.

19 [illegible]
(Date rec'd) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/7/48 2 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH arteriosclerotic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D. P. Culbreath M.D.
Medical Examiner.
Date signed 2/7/48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-87523 C59858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C59858 / 12 B

Registered No. C59858

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 26-12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3yrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 42yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. No Home (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Nicholson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4 1869

8. AGE: Years	Months	Days	If less than one day
78	9	29	hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name ?

13. Birthplace ?

MOTHER 14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospital

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md

18 (a) Funeral director Wilson & Son

(b) Address 1217 St Paul St

19 (a) [illegible] (b) Huntington, West Virginia

(Signature or address)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3 1948, at 12 40

21. I certify that death occurred on the date above stated; that I attended deceased from 4-19 1944 to 2-3 1948, and that I last saw him alive on 2-3 1948.

Immediate cause of death	Duration
Pulmonary Tuberculosis	4 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. E. Robinson Jr

Address Balt City, Md. Date signed 2/7/48 M.D.

X

G59859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G59859

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital 26-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 57 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5003 Greenhill Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Charles William Winkler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Elizabeth Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-12-90

8. AGE: Years 57 | Months 8 7 | Days 7 2 | If less than one day: 3 hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Balto. Transit Co.

FATHER
12. Name Peter C. Winkler
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret Reinfels
15. Birthplace Baltimore County, Md.

16 (a) Informant Mrs. C.W. Winkler
(b) Address 5003 Greenhill Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 2/9/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Lazarus Funeral Home
(b) Address 7401 Belair Road

19 (a) FEB 6 1948 Huntington Williams M.D. (Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5 1948, at 2.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-22 1948 to 2-5 1948, and that I last saw him alive on 2-5 1948

Immediate cause of death: Respiratory failure — Duration

Due to massive pontine hemorrhage

Due to hypertension C-V disease

Other Conditions mild congestive heart failure
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Joseph Krajci M. D.
Address 1400 N. Caroline St Date signed 2-5-48

V S 150

G59860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46 B

G59860 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3208 Foster Ave.
(c) Hospital or institution:

26

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) About 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3208 Foster Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MATTHEW BITZELBERGER.

3 (b) If veteran, name war ----
3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Walburga Bitzelberger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 5 1878

8. AGE: Years	Months	Days	If less than one day
69	11	29	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Laborer.

FATHER
12. Name ? Bitzelberger
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Genevieve Trageser (Daughter.)
(b) Address 3208 Foster Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-48. (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location 4701 German Hill Rd.

18 (a) Funeral director Charles L. Zeiler.
(b) Address 901 S. Conkling St.

19 (a) FEB 6 1948 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 15b

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4 1948, at 7:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1947 to Feb 4 1948.
and that I last saw h[illegible] alive on Feb 3 1948.

Immediate cause of death	Duration
Coronary Thrombosis	1946
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert J. Kleeman M. D.
Address 3426 Bank St Date signed Feb 6-48

X

659861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (55)

Registered No. 659861

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2104 McCulloh
(c) Hospital or institution: 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2104 McCulloh
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lottie Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Luther Taylor

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace NC
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Mitchell
13. Birthplace NC

MOTHER
14. Maiden Name Lucy Ann Mitchell
15. Birthplace NC

16 (a) Informant Luther Taylor
(b) Address 2104 McCulloh

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A. Co. Md.

18 (a) Funeral director: Metropolitan Funeral Home
(b) Address 922 N. Mount St

19 (a) FEB 6 - 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4 1948 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1947 to Jan 4 1948 and that I last saw h alive on Jan 4 1948

Immediate cause of death: Coronary Thrombosis

Duration: 8 m

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Watts

Address 5154 Belmont Date signed 2/5/48

VS 150

G59862a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G59862 Registered No.

116278 47a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution: 4-1
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18

(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town
(If outside city or town limits, write RURAL and give town)

(d) Street No. Market Place ? ?
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8th 1883

8. AGE: Years	Months	Days	If less than one day
64	6	12	hr. min.

9. Birthplace Mass.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Kelly
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Muaney
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/48 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart
Location Germantown Hill Rd

18 (a) Funeral director John J. Fahey & Sons
(b) Address 1308 Light St

19 (a) FEB 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 190

MEDICAL CERTIFICATION A.M

20. DATE OF DEATH January 20th 1948, at 5.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2nd 1948, to Jan. 20 1948 and that I last saw him alive on Jan. 20th 1948

Immediate cause of death Squamous cell Carcinoma of Larynx with widespread metastases — Duration 8 mos.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature H. S. Kasser M. D.

Address Baltimore City Hosp Date signed 2/5/48

G59863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G59863

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 940 Sharp Street

(c) Hospital or institution: 23-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 940 Sharp St (If rural, give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Augustus Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/15/1886

8. AGE: Years	Months	Days	If less than one day
61 62	2	17	hr. min.

9. Birthplace Calvert Co, Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Bellert Williams

(b) Address 940 Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem.

Location A. A. Co., Md

18 (a) Funeral director Isaiah L. Brown & Son

(b) Address 848 W Montgomery St

19 (a) FEB 6 - 1948 (Date rec'd by registrar) (b) Registered

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/2/48 19 , at 4A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1948, to 2/2 1948, and that I last saw h alive on 1/28 1948

Immediate cause of death Bly mne Pulmonary Tuberculosis

Due to

Due to

Other Conditions Bly Endocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Dan'l Trawler M. D.

Address 1YY L Lee Date signed 2/6/48

X

G59864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47F

G59864 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 13 W. 1st Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN S HALE

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-4399

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Grace E. Hale
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 23, 1880

8. AGE: Years	Months	Days	If less than one day
67	5	13	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Ch. chauffeur.
11. Industry or business Contintental Can Co.

FATHER
12. Name Elijah J. Hale.
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca Raystoning.
15. Birthplace Md.

16 (a) Informant Portia L. Schaenig.
(b) Address 13 W. 1st Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 9 1948 (month) (day) (year)
(c) Cemetery or crematory Poplar.
Location Baltimore Co.

18 (a) Funeral director Kenneth F. Donovan.
(b) Address 3605-7 Keswick Ave.

19 FEB 6 - 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 5 1948 at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15 1948 to 2-5 1948 and that I last saw him alive on 2-5 1948

Immediate cause of death	Duration
Lymphosarcoma of mediastinum	?
Due to	
Due to	
Other Conditions Thrombosis Pericarditis	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Allan Spier
Address Md. Gen. Hosp. Date signed Feb 6 48

G59865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. 159865

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 610 HIGHWOOD DR.
(c) Hospital or institution: 27-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 HIGHWOOD DR.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LUTHER E. CROOKS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	WIDOWED

6 (b) Name of husband or wife CATHERINE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 5, 1874

8. AGE: Years	Months	Days	If less than one day
74	1	0	hr. min.

9. Birthplace BALTO. COUNTY, MD.
(Town, county, and state)
10. Usual Occupation INTERIOR DECORATOR
11. Industry or business SELF

FATHER
12. Name WASHINGTON CROOKS
13. Birthplace BALTO. COUNTY

MOTHER
14. Maiden Name CLEMENTINE RITTER
15. Birthplace MD.

16 (a) Informant MRS. RALPH BAYLOR
(b) Address 734 NORTHERN PKWY.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/7/48 (month) (day) (year)
(c) Cemetery or crematory MT. OLIVE
Location BALTO COUNTY

18 (a) Funeral director WM J. TICHNER & SONS INC
(b) Address NORTH & PA. AVES. BALTO

19 (a) FEB 6 - 1948 (Date rec'd by registrar) (b) Huntington Hilliard M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1948, at 8.20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30 1948 to Feb 4 1948 and that I last saw him alive on Feb 4 1948.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Coronary Sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hiram Tried M. D.
Address 1316 Med. Arts Bldg. Date signed Feb 5/48

VS 150

C59866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C59866

1. PLACE OF DEATH:

(a) Baltimore City, Maryland North

(b) Street address 1113 Appelton St.

(c) Hospital or institution: -- 16-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1113 N. Appelton St
(If rural give location)

(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME LOUISA M. GUETHLEIN

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Frank M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 27, 1867

8. AGE: Years	Months	Days	If less than one day
80	1	6	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation --

11. Industry or business Voigt

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Anna
15 Birthplace

16 (a) Informant Miss Mildred A. Guethlein

(b) Address 1113 N. Appelton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/48 (month) (day) (year)

(c) Cemetery or crematory ~~XXXXXX~~ Lorraine

Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.

(b) Address North & Pa. Aves; Balto., Md.

19 (a) FEB 6 - 1948 (Date rec'd by Registrar) (b) Huntington Nelligan, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3, 1948 19 , at 1:20P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1939, to Feb 3 1948, and that I last saw her alive on Feb 1 19 48.

	Duration
Immediate cause of death Coronary Thrombosis	2 days
Due to Generalized Arteriosclerosis	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Norman R. Klemmer M. D.

Address 3803 Edmondson Ave Date signed 2/4/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1316

G59867 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 547-W. Lafayette Ave.
(c) Hospital or institution: Lab.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 547-W. Laf. Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ben Eaton.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-1874

8. AGE: Years 73 | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace Durham N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace N.C.

MOTHER 14. Maiden Name Unknown

15. Birthplace N.C.

16 (a) Informant Murrel Jones

(b) Address 547-W. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/48 (month) (day) (year)

(c) Cemetery or crematory Church Cemetery

Location Spring Hope N.C.

18 (a) Funeral director W. Blakstead

(b) Address 918-Linwood Hilldale

19 (a) 6-1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-5- 1948 at 8:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2 1948 to 2/5 1948 and that I last saw h alive on 2/4 1948

Immediate cause of death Pneumonia

Myocarditis

Due to Chronic Nephritis

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Saunders M.D.

Address Here See Date signed 2/6/48

VS 150

659868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

659868 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1039 W. Cross St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) 37 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1039 W. Cross St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Giuseppe Andreone

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife: Anna Andreone
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31 1866

8. AGE: Years	Months	Days	If less than one day
61	6	4	hr. min.

9. Birthplace Germignano Teramo Italy
(Town, county, and state)
10. Usual Occupation Shoemaker
11. Industry or business shoemaker Shop

FATHER
12. Name Antonio Andreone
13. Birthplace Italy

MOTHER
14. Maiden Name Maria Bonolis
15. Birthplace Italy

16 (a) Informant Yolanda Andreone
(b) Address 1039 W. Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 7/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Noce
(b) Address 52 N. Morley St.

19 Feb 6 1948 Huntington Williams, M.D. Registrar
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-4- 1948, at 7 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-7- 1947 to 2-4- 1948, and that I last saw him alive on 2-4- 1948.

Immediate cause of death	Duration
Myocardial infarction	2 mo.
Due to	
Due to	
Other Conditions Hypertensive CVD	?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Willard Hall
Address 111 E. Chase St. Date signed 2-5-48 M. D.

G59869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

Registration No. G59869

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1029 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Spence

3 (b) If veteran, name war: W. W 2

3 (c) Social Security Account No.: —

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: S

—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/13/1924

8. AGE: Years 23 | Months 10 | Days 21 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Ethera J. Spence
13. Birthplace Va

MOTHER
14. Maiden Name Myrtle Edmonds
15. Birthplace Va

16 (a) Informant Elsie Moore
(b) Address 1029 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/48 (month) (day) (year)
(c) Cemetery or crematory Northumberland
Location Northumberland Co. Va

18 (a) Funeral director Wed. B. Nelson
(b) Address 1303 Pressman St

19 (a) FEB 6 - 1948 (Registered by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4, 1948, at 10.05 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet-wound of brain.
Bullet-wound of left flank.
Due to Bullet-wound of left hip.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-4-48 at about 7 P.M.
(b) Where did injury occur? 1304 N. Fremont Ave. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms.
23. Signature George H. Merrill M.D. Medical Examiner.
Date signed 2-5-48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No. G59870

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2831 Chesterfield Ave
(c) Hospital or institution: 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2831 Chesterfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Berger

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Ida Berger

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Jan 23 - 1882

8. AGE: Years 66 | Months - | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation

11. Industry or business Grocer.

FATHER
12. Name Paul Berger.
13. Birthplace Austria

MOTHER
14. Maiden Name — Sandkoeger
15. Birthplace Austria

16 (a) Informant Paul Berger
(b) Address 3405 Ramona ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 7th (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Catty

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 3rd 1948, at 11 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1947 to Feb 3 1948 and that I last saw h[illegible] alive on Feb 3 1948

Immediate cause of death: Heart Failure — Duration: 2 days
Due to: malnutrition — 6 wks
Due to: Carcinoma Prostate — 2 yrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature William L. Feaney
Address 3025 Belair Rd Date signed 2-6-48 (M D)

VS 150

X

659871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 659871

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Give correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 Mt. Holly St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 Mt. Holly St., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert W. Sullivan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Cecelia D. Sullivan

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1883

8. AGE: Years 65 | Months 0 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Secretary

11. Industry or business Old Bay Line

FATHER
12. Name George Sullivan
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elizabeth J. Orr
15. Birthplace Ireland

16 (a) Informant Mrs. Cecelia Sullivan
(b) Address 405 Mt. Holly St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 FEB 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4, 1948, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 1945 to 2/4 1948, and that I last saw h/M alive on 2/4 1948

Immediate cause of death
(a) Acute Pulmonary Edema — Duration 2/4/48
Due to Hypertensive & Arteriosclerotic Heart Disease — 5+ yrs
Due to Chronic Nephritis — 10 yrs
Due to Chronic Interstitial Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Williams M. D.
Address 3629 Edmondson Date signed 2/6/48

G59872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G59872
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2316 Hunter Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lilly E Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 50 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Whitestone Va. (Town, county, and state)

10. Usual Occupation domestic

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant John H. Brown
(b) Address 1621 Lamall st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/48 (month) (day) (year)
(c) Cemetery or crematory
Location Western Star

18 (a) Funeral director Wm. A. Jackson
(b) Address 916 Penna ave

19 FEB 6 - 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/2/48 19..., at 11:35 AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D. (Medical Examiner.)
Date signed 2/3/48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

659873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

Registration No. 659873

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 540 E. 22nd Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY PADDY

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife George Paddy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1906

8. AGE: Years	Months	Days	If less than one day
41	1	21	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Charles D. Haugh
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Amelia J. Kuhn
15. Birthplace Baltimore, Md.

16 (a) Informant Charles R. Haugh
(b) Address 3541 Greenmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director No. 20. Means and Son
(b) Address 805 N. Calvert Street

19 (a) [illegible] (b) [illegible] Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1948, at 2.45 P.M.

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH 2nd° Burns & asphyxiation due to carbon-monoxide

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 9/8
(a) Date of injury 2-5-48 about 1 a. M.
(b) Where did injury occur? 540 E. 22nd St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury House afire

23. Signature Carl L. Mayer M.D.
Medical Examiner.
Date signed 2-5-48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

Registered No. G59874

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 13 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 540 E. 22nd Street. (If rural give location)
(e) Citizen of foreign country? ------- (Yes or No) If yes, name country --------

3 (a) FULL NAME GEORGE PADDY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife ----------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1934

8. AGE: Years	Months	Days	If less than one day
13	9 4	8	-- hr. -- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Student
11. Industry or business -------

FATHER
12. Name George McC. Paddy Sr.
13. Birthplace West River, Maryland

MOTHER
14. Maiden Name Mary A. Haugh
15. Birthplace Baltimore, Maryland

16 (a) Informant George McC. Paddy Sr.
(b) Address 3541 Greenmount Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) FEB 6 1948 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1948 at 2.45 a M

21. I certify that I took charge of the remains described above, held an insp.& inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH 2nd & 3rd Burn - asphyxiation due to Carbon-Monoxide

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 9/8
(a) Date of injury 2-5-48 at about 1 a. M. 540 E. 22nd St.
(b) Where did injury occur? Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury House afire

23. Signature Earl L. Royer M.D. Medical Examiner.
Date signed 2-5-48

VS 191

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59875

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G59875
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 Carson Court.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: MARY PROTHO

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 81 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace unknown
(Town, county, and state)

10. Usual Occupation Laundry Work

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Empire Laundry
(b) Address Winchester & Carey Sts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. Co. Md.

18 (a) Funeral director Metropolitan Funeral Home Inc.
(b) Address 927 N. Fremont St.

19 (a) Date rec'd by registrar FEB 6 1948 Washington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3, 1948, at 4.45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral embolism due to Diabetes Mellitus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Conrad Rogers M.D.
Medical Examiner.

Date signed 2-3-48

X

If any of the above items are unknown, state "unknown." Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G59876

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 11-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 Park Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAUDE FRANCES DONOVAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 1, 1880

8. AGE: Years	Months	Days	If less than one day
67	11	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Thomas F. Donovan
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Wm. J. Purcell
(b) Address 227 Elton Rd. Stewart

17 (a) Cremation (b) Date thereof 2/7/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5365 Harford Rd

19 (a) FEB 6 - 1948 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4, 1948, at 1.45 P M

21. I certify that I took charge of the remains described above, held an Inspection + Inq. thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardio-vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George C. Merrill M.D.
Medical Examiner.

Date signed 2/7/48

VS 181

Dr. Alessi

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G59877

G59877

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6405 Grindon Avenue
(c) Hospital or institution: 27-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6405 Grindon Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David Paul Sindall, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1876

8. AGE: Years	Months	Days	If less than one day
71	6	21	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name David Paul Sindall, Sr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Caroline A. Sacconde
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Eliza Sindall
(b) Address 6405 Grindon Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-48 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Govans, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) FEB 6 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4th, 1948 at 8:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1947 to Feb 4 1948 and that I last saw h[illegible] alive on Feb 4 1948

Immediate cause of death Carcinoma of the stomach — Duration 1 yr.

Due to

Due to Arteriosclerosis, generalized

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 6217 Harford Rd Date signed Feb 6 1948

V S 190

659878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 659878

659878

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3017 Ridgewood Ave
(c) Hospital or institution: ——— 15-H
(d) Length of stay in hospital or inst. (yrs., mos., or days) ———
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ———
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 N. Payson St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country ———

3 (a) FULL NAME Clinton Schneider

3 (b) If veteran, name war ——— 3 (c) Social Security Account No. ———

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife ———
6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) Nov. 1- 1901

8. AGE: Years	Months	Days	If less than one day
46	3	3	——— hr. ——— min.

9. Birthplace Baltimore - Md (Town, county, and state)
10. Usual Occupation Sheet Metal Worker
11. Industry or business Own Business

MOTHER / FATHER
12. Name Henry Schneider
13. Birthplace Maryland
14. Maiden Name Atlanta Paulson
15. Birthplace Maryland

16 (a) Informant Mrs. Virginia Klein
(b) Address 3017 Ridgewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 6-48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn - Md

18 (a) Funeral director F. B. Wippert - Son
(b) Address 1300 Eutaw Pl. 17.

FEB 6 1948 (b) Huntington Williams, M.D.
Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4th 1948 at 3 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1- 1947 to Feb. 4 1948 and that I last saw him alive on Feb. 4 1948.

Immediate cause of death	Duration
Ch. Pulmonary Tuberculosis	1944
Due to	
Due to Ch. myocarditis	1947
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation ———
Major findings of operation: ———
of autopsy: ———

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ———
(b) Date of occurrence ——— at ——— M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? ———
(e) Means of injury ———

23. Signature Paul E. Brown
Address 1663 W North Ave. Date signed 2/5/48 M. D.

VS 150

G59879

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G59879

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1128 Druid Hill Ave.
(c) Hospital or institution: 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Parsons Waller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Isaac Waller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/31/1872

8. AGE: Years 75 (76) | Months 1 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Delmar, Delaware
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Moses Parsons
13. Birthplace

MOTHER
14. Maiden Name Sarah Burington
15. Birthplace

16 (a) Informant Clara Parker
(b) Address 4301 Greenway

17 (a) Burial (b) Date thereof 2 7 '48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Brooklyn, Md.

18 (a) Funeral director Joseph L. Russ
(b) Address 1200 McCulloh St.

19 (a) FEB 6 - 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb - 4 - 1948 at 2p M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/2 1948 to 2/4 1948, and that I last saw h[illegible] alive on 2/2 1948.

Immediate cause of death Terminal Uremic pneumonia — Duration 4 days
Due to Cardiovascular Renal disease — Duration 1 yr
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address 6000 Arlington Ave Signed 2/6/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G59880 129 S. B.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G59880

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 241 S. Broadway
(c) Hospital or institution: 2-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 241 S. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John M. Maddox

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Barbara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/23/1894

8. AGE: Years	Months	Days	If less than one day
53	6	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Elevator Operator

11. Industry or business O'Sullivan Building

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Family
(b) Address Same

17 (a) B (Burial, cremation, or removal) (b) Date thereof 2/9/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway

18 (a) Funeral director James L. McCauley
(b) Address 130 E. Fort Ave.

19 FEB 6 - 1948 (Date rec'd by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1948, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11 1946 to Feb 5 1948, and that I last saw him alive on Feb 5 1948

Immediate cause of death: Chronic myocarditis
Coronary thrombosis — Duration 2 yrs 1948, 1 day 1948

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton L. Solomon

Address 129 S. Bentley Date signed 2/6/48

G59881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G59881 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1301 Park Ave.

(c) Hospital or institution: nursing home 14-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County none

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1700 Bolton St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ella A. Rinker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1884

8. AGE: Years	Months	Days	If less than one day
63	6	24	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Practical nurse

11. Industry or business

FATHER

12. Name Robert S. Rinker

13. Birthplace Va.

MOTHER

14. Maiden Name Mary E. Zehring

15. Birthplace Va.

16 (a) Informant Maggie R. Stover

(b) Address Gaithersburg, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/48 (month) (day) (year)

(c) Cemetery Otterbein

Location Mt. Jackson, Va

18 (a) Funeral director John O. Mitchell & Sons, Inc.

(b) Address 1900 Eutaw Place

19 (a) FEB 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1948 19 , at 3 39 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 to Feb 5 1948. and that I last saw her alive on Feb 4 1948.

Immediate cause of death Carcinoma Left Breast. — Duration 8 yrs.

Due to Metastases - lungs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature W. H. Rady M. D.

Address 1403 Park Ave. Date signed 2-6-48

VS 150

C59882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

C59882 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton Ave.
(c) Hospital or institution: nursing home 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Park Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Clara D. Ridgely Garrett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Frank L. Garrett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 21, 1861

8. AGE: Years 86 | Months 5 | Days 15 | If less than one day: hr. min.

9. Birthplace Prince George Co., Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Arthur Pue Ridgely
13. Birthplace Md.

MOTHER
14. Maiden Name Selah Waters
15. Birthplace Md.

16 (a) Informant Records, Baptist Home
(b) Address 1615 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/48 (month) (day) (year)
(c) Cemetery ~~Greenmount~~ Lorraine
Location Windsor Mill Rd., Baltimore

18 (a) Funeral director John O. Mitchell & Son, Inc.
(b) Address 1900 Eutaw Place

19 (a) FEB 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1947 to Jan 1948, and that I last saw h er alive on Jan 15 1948.

Immediate cause of death: Carcinoma of Ovary — Duration: 1 yr.

Due to

Due to

Other Conditions Hypertension and Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation Sept 28, 1947

Major findings of operation: Pelvis Carcinomatosis of ovarian origin

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. L. Benoff M. D.
Address 2240 Eutaw Place Date signed Feb 6 1948

1-3 - Dr. Benoff X

059883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 059883

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 339 Scott St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 339 Scott Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM O. RIDDELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, ~~1914~~ 1913

8. AGE: Years	Months	Days	If less than one day
34 (35) mnt	4 5	30	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Elisha (~~Ellen~~) Riddell
13. Birthplace Richmond, Va.

MOTHER
14. Maiden Name Margaret Hopwood
15. Birthplace Frederick, Md.

16 (a) Informant Margaret Riddell
(b) Address 339 Scott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Frederick Road

18 (a) Funeral director Howard J. Blight Jr.
(b) Address 4914 Belair Road

19 FEB 6 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1948, at 8 p. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subdural hemorrhage, right, spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil Rogen M.D.
Medical Examiner.
Date signed 2-5-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C59884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. C59884

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2528 Edmondson Ave.
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2528 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F. Beggerow Jr.

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 217-09-721

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Jessie I.

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) March 12, 1892

8. AGE: Years 55 | Months 10 | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business May C o., Dept. Store

FATHER
12. Name Charles F. Beggerow Sr.
13. Birthplace Germany

MOTHER
14. Maiden Name Theresa Lipcott
15. Birthplace Germany

16 (a) Informant Mrs Jessie I. Beggerow
(b) Address 2528 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director FREOK. A. Cole
(b) Address 1201 W. LOMBARD ST

19 (a) Filed FEB 6 - 1948 (b) Registrar Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5, 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1947 to Feb 5 1948 and that I last saw him alive on Feb 5 1948.

Immediate cause of death, Carcinomatosis (Primary)
Due to Unknown
Due to
Other Conditions Hypernephroma.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert C. Peterkin M. D.
Address 715 Wilkens Av Date signed Feb 6 1948

V S 150

C59885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. C59885

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: BALTIMORE CITY HOSPITAL 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 6B
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 844 N. Powers Street. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM O. KLOHR

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 218-07-2685

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Margaret Virginia Jones Klohr

6 (c) If alive, give age: 33 years

7. Birth date of deceased (mo., day, yr.) April 9, 1907

8. AGE: Years: 40smt | Months: 9 | Days: 25 | If less than one day: 26 hr. ..... min.

9. Birthplace: Randallstown Balto Co Md (Town, county, and state)

10. Usual Occupation: Engineer-Pwr Plnt-G Mtrs

11. Industry or business: -

FATHER
12. Name: Wm Murray Klohr
13. Birthplace: Randallstown Md

MOTHER
14. Maiden Name: Rhoda Owings
15. Birthplace: Garrison Md

16 (a) Informant: Mrs William Klohr
(b) Address: 844 Powers St Balto Md

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof 2/9/48 (month) (day) (year)
(c) Cemetery or crematory: Mt Olive Cemetery
Location: Randallstown Md

18 (a) Funeral director: Wm Berryman & Sons
(b) Address: Reisterstown Md

19 (a) FEB 6 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1948, at 1.20 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Acute congestive cardiac failure, with dilatation of heart and acute edema of lungs.

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: George L. Merrill M.D. Medical Examiner.
Date signed 2-5-48

VS 181

X

Please write in ink, with CAPITAL LETTERS. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C59886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C59886 / 309

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1229 N. Gay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elizabeth Walker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

(b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-17-25

8. AGE: Years 22 | Months 8 | Days 19 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Louis Walker
13. Birthplace ? Va

MOTHER
14. Maiden Name Arlean Wilkinson
15. Birthplace ? Va

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 2-7-48 (month) (day) (year)
(c) Cemetery or crematory White Plains
Location Virginia

18 (a) Funeral director Rayner Sanders
(b) Address 1112 E. Preston St

19 (a) FEB 6 - 1948 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5 1948, at 1-10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 4 1948 to Feb 5 1948, and that I last saw h[er] alive on Feb. 5 1948.

Immediate cause of death: Subarachnoid hemorrhage — Duration: 24 hrs
Due to: Cong. Aneurysm
Due to:
Other Conditions: Late Lues, Syphilis treated
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None permitted

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Victor A. McKusick
Address Johns Hopkins Date signed 2/5/48 M. D.

Thomas J. Huckins, M.D.

VS 150

G59887

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G59887

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 800 N. Castle St D.O.A.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 800 N. Castle St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Svec

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Wenceslaus Svec
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1874

8. AGE: Years	Months	Days	If less than one day
73 (73)	2	1	hr. min.

9. Birthplace Cumberland Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Nemick
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Mrs. Marie Weber
(b) Address 803 N. Castle, St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 2-7-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Charles Schemmel
(b) Address 2601 E. Madison St.

19 (a) FEB 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/4 1948, at 12:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive - Arteriosclerotic Cardio - Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed 2/4/48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G59888

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3230 Elliott St.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3230 Elliott St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph A. Winiecki

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 21 1923

8. AGE: Years	Months	Days	If less than one day
24	3	15	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William J. Winiecki
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Frances Makowske
15. Birthplace Baltimore Md.

16 (a) Informant William J. Winiecki
(b) Address 3230 Elliott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/48 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Ave.

18 (a) Funeral director John J Duda
(b) Address 2829 Hudson St

19 (a) FEB 6 1948 (Date rec'd by registrar) (b) Wilfred Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 FEB 1948, at 5.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4 FEB 1948 to 5 FEB 1948, and that I last saw h[illegible] alive on 4 FEB 1948.

Immediate cause of death	Duration
CEREBRAL HEMORRHAGE	1 HR
Due to STATUS EPILEPTICUS	24 HRS
Due to EPILEPSY	17 YRS
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Bigbatus M. D.
Address 121 S. HIGHLAND AVE Date signed 5 FEB 48

VS 150

59889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓167

Registered No. 59889

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1916 Edmondson Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NATHANIEL DAUGHERTY

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 23, 1929

8. AGE: Years	Months	Days	If less than one day
18 mt	5	6	hr. min.

9. Birthplace Norfolk, Va.
(Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business

FATHER
12. Name Ambrose Daugherty
13. Birthplace Hartford Co., Md.

MOTHER
14. Maiden Name Ruth Hayes
15. Birthplace Norfolk, Va.

16 (a) Informant Mr. Joseph Reed
(b) Address 540 W. Lanvale Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 6 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) FEB 6 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1, 1948, at 1.30 M a

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gun wound of abdomen involving aorta

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-1-48 at 12.30 a. M.
(b) Where did injury occur? 1916 Edmondson Ave. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Sharp instrument

23. Signature [signature] M.D.
Medical Examiner
Date signed

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No. G59890

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1843 Druid Hill ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1843 Druid Hill ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Frances Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1888

8. AGE: Years 59 | Months 7 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John H Brown
13. Birthplace St Marys co Md

MOTHER
14. Maiden Name Elizabeth Perkins
15. Birthplace St. Marys co. Md

16 (a) Informant George Bell
(b) Address 1843 Druid Hill ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk
Location Baltimore Co. Md

18 (a) Funeral director Mrs. Lee H. Holland
(b) Address 1631 Harlem Hill Ave. Huntington Williams, M.D.

19 (a) FEB 6 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION 40

20. DATE OF DEATH Feb 4 1948, at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 31 1948 to Feb 4 1948 and that I last saw h alive on Feb 4 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Hypertension	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Edward Fisher M. D.
Address 2 E Monument Date signed Feb 6 48

VR 150

OLIVER C. PEDDICORD

659891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 659891

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-6
(e) Length of stay in Baltimore (yrs., mos., or days) 70 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3545 Chestnut Avenue (If RFD, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Oliver C. Peddicord

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Edna M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17 - 1871

8. AGE: Years 76 | Months 10 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace: Howard Co. Maryland (Town, county, and state)

10. Usual Occupation: Mt. Vernon-Woodberry Mills

11. Industry or business: Retired 55 years

FATHER
12. Name: Benjamin F. Peddicord
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Margaret Dorsey
15. Birthplace: Maryland

16 (a) Informant: E. C. Peddicord
(b) Address: 8734 Loch Bend Drive, Towson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 7. 1948 (month) (day) (year)
(c) Cemetery or crematory: St. Mary's (Hampden)
Location: Baltimore, Maryland

18 (a) Funeral director: Burgee Funeral Home
(b) Address: 303 Falls Road

19 (a) FEB 6 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 Feb. 1948, at 9:42A M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D. Medical Examiner.
Date signed 5 Feb. 48

X

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

47c

059892 059892

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1605 N. Wolfe Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 N. Wolfe Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John R. Graff

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2 1906

8. AGE: Years	Months	Days	If less than one day
41 42	6	2	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Milkman
11. Industry or business

FATHER
12. Name Phil Graff
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Rose Stanonyshi Graff
(b) Address 1605 N. Wolfe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John Jr. Webley
(b) Address 401 S. Chester Street

19 FEB 6 - 1948 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION 10 ss

20. DATE OF DEATH Feb 4 1948, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1947 to Feb. 4 1948 and that I last saw him alive on Feb. 4 1948.

Immediate cause of death	Duration
Pulmonary Hemorrhage	15 min.
Due to Bronchogenic Carcinoma of Lung	3 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ernest Lewis, M.D.
Address 1601 N. Broadway Date signed 2/6/48

VS 150

C59893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. C59893

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WITH PENCIL, WITH UNFADING INK.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1714 E. Monument St.

(c) Hospital or institution: Sinai Hospital of Baltimore

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5735 Govane Avenue (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katherine Lahey

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife John Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 3, 1885

8. AGE: Years	Months	Days	If less than one day
62	0	2	hr. min.

9. Birthplace Mass. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name James W. Ryan

13. Birthplace Salem, Massachusetts

MOTHER

14. Maiden Name Ella Creamer

15. Birthplace Salem, Massachusetts

16 (a) Informant John C. Barrett

(b) Address 5735 Govanne Avenue

17 (a) removal (Burial, cremation, or removal) (b) Date thereof 2/6/48 (month) (day) (year)

(c) Cemetery or crematory St. Mary's

Location Salem, Massachusetts

18 (a) Funeral director Wm. Cook, Inc.

(b) Address 1217 St. Paul Street

19 FEB 6 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5, 1948, at 11 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6 1948 to 2-5 1948, and that I last saw h alive on 2-5 1948.

Immediate cause of death	Duration
Cardiac Failure	
Due to	
Due to	over
Other Conditions Generalized Carcenomatosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Generalized Carcinoma

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Ernest Dever

Address Sinai Hosp. Date signed 2/9/48

VS 193

G59894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G59894 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2621 Fleet St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Gaurman

3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Christian J.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) 9-8-1865

8. AGE: Years	Months	Days	If less than one day
82	4	28	..... hr. ..... min.

9. Birthplace Penn (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Balto. County Welfare
(b) Address 209 Wash. Ave. Towson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-1948 (month) (day) (year)
(c) Cemetery or crematory St. Matthia
Location O'Donnell St.

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 S. Wolfe St.

19 FEB 6 - 1948 (Date rec'd by Registrar) (by) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1948 at 12.05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1948 to Feb 6 1948, and that I last saw her alive on Feb 3 1948

Immediate cause of death	Duration
Uremic Coma	3 days
Due to Chronic Nephritis	?
Due to Hypertension	?
Other Conditions Myocardial Degeneration ?	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank Levinson M. D.
Address 4004 Eutaw Place Date signed 2/6/48

VS 150

X

G59895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G59895 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 603 S. Robinson St.
(c) Hospital or institution: — — none — — —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County — — — —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 603 S. Robinson St. (If rural, give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country — — — — —

3 (a) FULL NAME Margaret Schwartz

3 (b) If veteran, name war — — — —

3 (c) Social Security Account No. — — — —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife James Schwartz (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Apr. 14, 1872

8. AGE: Years	Months	Days	If less than one day
75	9	20	..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name John Herr
13. Birthplace Germany

MOTHER
14. Maiden Name Bertha Liebhardt
15 Birthplace Germany

16 (a) Informant James Schwartz - Hus.
(b) Address 603 S. Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave. East.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. Dolfe St. (31)

19 (c) (Date rec'd by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4, 1948 at 10:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Octob. 10 1947 to Febr. 4 1948 and that I last saw her alive on Febr. 4 1948

Immediate cause of death	Duration
Cerebral Haemorrhage	16 months
Due to Essential Hypertension	Unknown
Due to	
Other Conditions Infected Bed sores	6 months

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. A. Rosenblatt M. D.
Address 3018 O'Donnell St. Date signed 2-6-48

VS 150

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

659896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

659896 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 527 S. Paca St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 527 S. Paca St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country Italy

3 (a) FULL NAME Flora Faraino

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~xxxx~~ late Francesco
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14 1866

8. AGE: Years 81 | Months 2 | Days 21 | If less than one day hr. min.

9. Birthplace Cefalu Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Francesco Leone
13. Birthplace Italy

MOTHER
14. Maiden Name Ignazia Brocato
15. Birthplace Italy

16 (a) Informant Frank Faraino (Son)
(b) Address 527 S. Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 7/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd. Baltimore

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) FEB 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-4- 19 48 at 7.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1 19 48 to 2-4 19 48 and that I last saw h 3 alive on 2-3- 19 48.

Immediate cause of death: Chronic nephritis cardiac decompensation — Duration 2 yrs
Due to:
Due to: Streptococcus infection — Duration 2 days.
Other Conditions: old age
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. Edward Della Rocca M. D.
Address Medical Arts Bldg. Date signed 2-6-48

059897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

77c

Registered No. 059897

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1553 Leslie Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ALEX TURNER

3 (b) If veteran, name war

3 (c) Social Security Account No. 117-01-1796

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Selma, N. C. (Town, county, and state)

10. Usual Occupation Dishwasher

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Calona Turner
15. Birthplace Selma, N. C.

16 (a) Informant Evelyn Carroll
(b) Address 1604 Vincent St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-48 (month) (day) (year)
(c) Cemetery or crematory ?
Location Selma, N. C.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.

19 (a) FEB 6 – 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 1948, at 8:30 A M

21. I certify that I took charge of the remains described above, held an Partial Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl C. Ryder M.D. Medical Examiner.
Date signed 2-5-48

VS 181

X

59898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 59898

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 N Washington ST (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. ELIZABETH KOFRON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Joseph Kofron
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10-20-57

8. AGE: Years	Months	Days	If less than one day
90	3	15	hr. min.

9. Birthplace BOHEMIA (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business

FATHER
12. Name FRANK PELISCK
13. Birthplace BOHEMIA

MOTHER
14. Maiden Name MARY MLZERAK
15. Birthplace BOHEMIA

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Joseph Lovedan
(b) Address 900 N. Eberton St

19 (a) FEB 7 - 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 4 1948, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-22 1948, to 2-4 1948, and that I last saw HER alive on 2-4 1948.

Immediate cause of death CARDIAC DECOMPENSATION & FRACTURE OF RIGHT HIP — Duration CHRONIC 1-21-48

Due to A FALL AT HOME

Due to

Other Conditions AURICULAR FIBRILATION (Include pregnancy within 3 months of death)

Date of operation 1-24-48

Major findings of operation: NONE (WIRE FOR TRACTION)

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 7/5
(a) Accident, suicide, or homicide ACCIDENT
(b) Date of occurrence 1-21-48 at 9 P M
(c) Where did injury occur? Baltimore (City or town) MD (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? HOME (Specify type of place) While at work? N.
(e) Means of injury GOING TO COMMODE

23. Signature O. D. Chaseman M.D.
Address Johns Hopkins Hosp Date signed 2-9-48
For J. R. Lowe, by Thomas J. Mullin M.D.

X

159899

GM. 115705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

136

Registered No. 159899

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Talbot
(c) City or town Oxford
(If outside city or town limits, write RURAL and give town)
(d) Street No. Oxford MD.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9 - 1941

8. AGE: Years	Months	Days	If less than one day
6	8	27	hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Franklin Gibson
13. Birthplace MD.

MOTHER
14. Maiden Name Florence Green
15. Birthplace MD.

16 (a) Informant Records Balto City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/48 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Talbot County

18 (a) Funeral director Lewis H Baynum
(b) Address 301 Washington Street Cambridge Md

19 (a) FEB 7 - 1948 (Date rec'd by registrar) (b) Cambridge Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 6 - 1948 at 11.08 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 - 5 1947 to 2 - 6 - 1948, and that I last saw him alive on 2 - 6 - 1948

Immediate cause of death — Duration
Miliary Tuberculosis — 2 mo
Tuberculous Meningitis — 2 mo
Due to
Due to
Other Conditions Cystitis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as listed above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arnold H Becker
Address Balto Cy Hosp Date signed 2/6/48 M. D.

659900 BC-C 70776 BALTIMORE CITY HEALTH DEPARTMENT 659900
GM. 117189 CERTIFICATE OF DEATH Registered No. 107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 51 Min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town North Point Creek Balto. Co. (If outside city or town limits, write RURAL and give town)
(d) Street No. RT. 10 Box A 259 North PT. Creek (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Forbes

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8 - 1947

8. AGE: Years	Months	Days	If less than one day
	11½	27	hr. min.

9. Birthplace MD (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name John Forbes
13. Birthplace VA.

MOTHER 14. Maiden Name Susie Adams
15. Birthplace W.VA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/48 (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 FEB 7 - 1948 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 5 - 1948, at 8.36 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5-48 1948, to 2-5-1948, and that I last saw him alive on Feb. 5 1948

Immediate cause of death Pneumonia, left — Duration 48 hr.
Due to
Due to — Duration ...ved
Other Conditions Atelectasis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arnold H Becker
Address Balto City Hosp Date signed 2/8/48 (M. D.)

VS 150

659901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 659901

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1817 Aisquith Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 65 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 Aisquith Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Norris E. Woodroe

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Augusta Haupt

6 (c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): May 23rd. 1872

8. AGE: Years 75 | Months 8 | Days 13 | If less than one day ########## min.

9. Birthplace: Baltimore County
(Town, county, and state)

10. Usual Occupation: Barber

11. Industry or business: Barber-shop

FATHER
12. Name: Benjamin Woodroe
13. Birthplace: Baltimore County, Md.

MOTHER
14. Maiden Name: Elizabeth Norris
15. Birthplace: Baltimore County, Md.

16 (a) Informant: Mrs. Augusta Woodroe (Wife)
(b) Address: 1817 Aisquith Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Frederick Avenue, Balto: Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) FEB 7 - 1948 (Date received by registrar) (b) Printing for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 th 1948, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1946, to Feb. 5 1948.
and that I last saw h.. alive on Feb 5 1948.

Immediate cause of death	Duration
CHRONIC MYOCARDITIS	
WITH MYOCARDIAL DEGENERATION	2 years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Jos Tannenbaum

Address 1150 E. Northern Date signed Feb 4, 1948 M. D.

V S 150

Tannenbaum +

G59902 BC-48-02263 JL -116996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161C

Registered No. G59902

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Av.
(c) Hospital or institution: Baltimore City H spitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 2 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 Leadenhall St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Taylor- Susie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1948

8. AGE: Years	Months	Days	If less than one day
			2 hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Leroy Taylor
13. Birthplace S. C.

MOTHER
14. Maiden Name Susie McKnight
15. Birthplace S. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 9am-1-29-48 (month) (day) (year)
(c) ~~Cemetery~~ crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) FEB 7 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

11 AM

20. DATE OF DEATH Jan. 28 1948, 6:05 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 28 1948, to Jan. 28 1948, and that I last saw h im alive on Jan. 28 1948.

Immediate cause of death	Duration
asphyxia	
Due to see below	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Polycystic kidneys; anemia hem

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Fetter M. D.
Address Baltimore City Hospitals Date signed 2-5-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

59903 JL - 116950 **CERTIFICATE OF DEATH** 159 Registered No. 59903

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Bowgue Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Campbell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27, 1948

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Lea L. Campbell
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 2-2-48 AT 9,00 AM (month) (day) (year)
(c) ~~Cemetery~~ or crematory B.C.H.
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) FEB 7 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29 1948, at 6.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 27 1948, to Jan. 29 1948, and that I last saw her alive on Jan. 29 1948.

Immediate cause of death	Duration
Prematurity	2 days
Due to	
Due to	
Other Conditions Fetal atelectasis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Prematurity & atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leopold H Becker M. D.
Address Balto City Hosp. Date signed 2/3/48

V5 150

659904 GC 48-62174 AB-117037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 200a

Registered No. 659904

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1069 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Hanes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29- 1948

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER | FATHER

12. Name John Marshburn

13. Birthplace ?

14. Maiden Name Naomi Hanes

15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 2-2-48 AM (month) (day) (year)

(c) ~~Cemetery~~ or crematory B.C.H.

Location 4940 Eastern Ave.

18 (a) Funeral director

(b) Address Huntington Williams, Md

19 (a) FEB 7 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30- 1948, at 12noon M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-29- 1948 to 1-30- 1948 and that I last saw him alive on 1-30- 1948

Immediate cause of death Cerebral Anoxia — Duration 1day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Cerebral Anoxia

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold H. Beaker M. D.

Address Balt City Hosp Date signed 2/5/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

059905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 059905

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1645 N. Fulton Ave.
(c) Hospital or institution:

15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1645 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Nottingham

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Lula Nottingham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1874

8. AGE: Years	Months	Days	If less than one day
73	11	11/0	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Butler
11. Industry or business

FATHER
12. Name James Nottingham
13. Birthplace Va.

MOTHER
14. Maiden Name Susie ?
15. Birthplace Va.

16 (a) Informant Mrs. Lula Nottingham
(b) Address 1645 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-48 (month) (day) (year)
(c) Cemetery or crematory Piney Grove
Location Baltimore Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) Feb 7 1948 (Date rec'd by Registrar) (b) [illegible] Registrar

V S 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Feb. 5, 1948, at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/21 19[illegible] to 2/5 19[illegible]
and that I last saw h[illegible] alive on 2/5 19[illegible]

Immediate cause of death	Duration
Coronary Occlusion	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed 2/7/48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 659906

659906 BC: C 96053 104

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1531 N. Stricker Stree
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1531 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sharon L. Foster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female (Female) | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1947

8. AGE: Years | Months 1 | Days 30 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Ffederick Foster
13. Birthplace N. C.

MOTHER
14. Maiden Name Regenia Butler
15. Birthplace Md.

16 (a) Informant Mrs. Regenia Butler
(b) Address 1531 N. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) FEB 7 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Feb. 5 1948, at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/29 1948 to 2/5 - 1948 and that I last saw him alive on 2/5 - 1948

Immediate cause of death Coma Pneumonia — Duration 1

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jno. Roberts M. D.
Address 27 W. Date signed 2/6

V S 150

659907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 659907

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Northern Pkwy and Sherwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. Northern Pkwy and Sherwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Wormsley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace Queen Annes Co (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Robt. Russelbaugh
(b) Address 6000 Bellona Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md

18 (a) Funeral director Maud Traynor & Hensley
(b) Address 518 W. Biddle St

19 (a) FEB 7 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/2 1948, at 1.20 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic CV Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Sulbrooke M.D. Medical Examiner.
Date signed 2/2/48

VS 151

...correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C59908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C59908

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Pikesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7010 Alder Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ETHEL REDDING

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Paul F. Redding

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1899

8. AGE: Years 48 | Months 5 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: --

FATHER
12. Name: Charles H. Rochner
13. Birthplace: --

MOTHER
14. Maiden Name: -- Kunkle
15. Birthplace: --

16 (a) Informant: Mr. Paul F. Redding
(b) Address: 7010 Alden Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/48 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Druid Ridge
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS INC.
(b) Address: North & Pa. Aves; Balto., Md.

19 FEB 7 - 1948 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1948, at 2.45 P M

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Asphyxiation due to carbon monoxide poisoning

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-5-48 at about 2 p. M.
(b) Where did injury occur? 7010 Alder Road, Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Illuminating gas

23. Signature Dr. John H. DeVilis per H. A. Merrill M.D.
Medical Examiner.

Date signed 2-6-48

VS 181

G59909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

G59909 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th STREET
(c) Hospital or institution: Home for Incurables 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4yrs-10 mon-15 day
(e) Length of stay in Baltimore (yrs., mos., or days) 46

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th STREET.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss MARGARET McDERMOTT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug-26-1877

8. AGE: Years	Months	Days	If less than one day
70	5	10	hr. min.

9. Birthplace IRELAND
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name PATRICK McDERMOTT
13. Birthplace IRELAND.

MOTHER
14. Maiden Name MARGARET REYNOLDS McDERMOTT
15. Birthplace IRELAND

16 (a) Informant HOME for INCURABLES
(b) Address 700 W. 40th ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Wm. J. Ticknor & Sons
(b) Address North & Ayres.

19 (a) (Date rec'd by Registrar) (b) Registrar's Signature

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5 1948, at 3.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 21 1943, to Feb. 5 1948, and that I last saw h.er alive on Feb 4 1948

Immediate cause of death	Duration
Congestive Heart Failure	2 weeks
Due to Hypertensive Cardio Vascular Disease	20 years
Due to	
Other Conditions Hypertrophic Arthritis	20 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Conrad Wolf M.D.
Address 11 E. Chase St. Date signed 2/6/48
Baltimore 2 Maryland

VE 3

59910

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. 59910

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts
(c) Hospital or institution: Franklin Square
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Sparrows Point - Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1220 Forest Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beatrice L. Richardson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Charles A. Richardson
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) April 22 1890

8. AGE: Years 57 | Months 9 | Days 14 | If less than one day: hr. min.

9. Birthplace Midland, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name O'Malley Durkin
13. Birthplace Midland, Md.

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Charles A. Richardson
(b) Address 1220 Forest Rd. Sparrows Pt. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 4914 Belair Road

19 (a) 2-1948 (Date rec'd by registrar) (b) Christopher Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 1948, at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/28 1948, to 2/5 1948, and that I last saw her alive on 2/5 1948.

Immediate cause of death: cerebral hemorrhage

Due to: hypertensive cardio-vascular disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bobby L. Jones M. D.
Address Franklin Square Hosp. Date signed 2/5/48

VS 150

Ida E. Stansfield

059911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a

Registered No. 059911

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Hampstead
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida E. Stansfield

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Samuel C Stansfield
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) June 21-1882

8. AGE: Years	Months	Days	If less than one day
66	—	15	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Columbus Elsewood
13. Birthplace Maryland

MOTHER
14. Maiden Name Ellen Annacost
15. Birthplace Maryland

16 (a) Informant Samuel C Stansfield
(b) Address Hampstead Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb-9-48 (month) (day) (year)
(c) Cemetery or crematory Wesley
Location Carroll Co Md

18 (a) Funeral director Edw C Tipton
(b) Address Hampstead Md

19 (a) FEB 7 • 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 1948, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1947, to Feb 6 1948.
and that I last saw h alive on 19

Immediate cause of death	Duration
Anoxemia	
Due to Pulmonary complications because of sepsis	
Due to Metastatic ca of ovary	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Jan 21 1948
Major findings of operation: Metastatic carcinoma of ovary
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Hollingsworth M. D.
Address Union Mem. Hosp. Date signed 2-6-48

VS 150

Hollingsworth X

G59912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 13B

Registered No. G59912

PRESS WRITE FIRMLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dor
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 507 Wilson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Rideout

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M.

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Violet

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1918

8. AGE: Years 29 | Months 6 | Days 1 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Entertainer

11. Industry or business Public

FATHER
12. Name Oliver Rideout
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Marie Reed
15. Birthplace Md.

16 (a) Informant Sterling Rideout
(b) Address 507 Wilson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-48 (month) (day) (year)

(c) Cemetery or crematory
Location Mt Calvary, Md.

18 (a) Funeral director A. Hailstead
(b) Address 918 Druid Hill Ave.

19 (a) FEB 7 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1st 1948, at 6:05 P.M.

21. I certify that I took charge of the remains described above, held an Inq & Chap Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature W Williams T Kelly M.D.
Medical Examiner.

Date signed 2/2/48

T659913 GM 117050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G59913

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Balto. City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11Hrs 40 Min.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 743 Sarah Ann ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilhelmina Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
80 ?			hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals
(b) Address 4040 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof 2/7/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Wm. Katen R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by Registrar) (b) Registrar

FEB 7 1948 Hunting for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-30-48 19 48 at 11.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-30-48 19 48 to 1-30- 19 48, and that I last saw her alive on Jan. 30- 19 48.

Immediate cause of death Congestive heart failure with pulmonary edema.
Due to Arteriosclerotic cardio-vascular disease.
Due to
Other Conditions Arteriolar nephro-sclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Pyelonephritis, Calot

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Vinton MD
Address Balto City Hosp Date signed 2 Feb 48

937

G59914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G59914 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St.
(c) Hospital or institution: Good Samaritan Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Unknown (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Allen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	?

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1875

8. AGE: Years	Months	Days	If less than one day
72		?	hr. min.

9. Birthplace ? (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Good Samaritan Hosp.
(b) Address 27 N Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 7 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1948 at 4:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 31 1947 to Feb 5 1948, and that I last saw h[illegible] alive on Feb 5 1948.

Immediate cause of death	Duration
Arteriosclerosis	
Due to	
Due to Stomach Cancer	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theo Kalaitzakis M. D.
Address 27 N. Carey Date signed 2/5/48

G59915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G59915

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert
(c) Hospital or institution: Mercy Hosp. 15 W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 McKeam Ave. #17 (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country —

3 (a) FULL NAME Charles H. Jameson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	married.

6 (b) Name of husband or wife Rebecca Jameson
6 (c) If alive, give age 88 years

7. Birth date of deceased (mo., day, yr.) Mar. 6, 1881

8. AGE: Years	Months	Days	If less than one day
66	11	—	....hr. ....min.

9. Birthplace Southern, Md. (Town, county, and state)
10. Usual Occupation State weighing clerk
11. Industry or business

FATHER
12. Name Charles H. Jameson.
13. Birthplace Brain Town, Md. Charles Co.

MOTHER
14. Maiden Name Anna Thompson
15. Birthplace Chaptico, Md.

16 (a) Informant Rebecca Jameson.
(b) Address 1917 McKeam Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 2-11-48 (month) (day) (year)
(c) Cemetery or crematory Bryantown
Location Bryantown Md

18 (a) Funeral director Hamett & Hyson
(b) Address Waldorf Md

19 (a) FEB 7 - 1948 (Date rec'd by registrar) (b) Arlington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 1948, at 11:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 16 1948 to Feb 6, 1948 and that I last saw him alive on Feb. 6, 1948.

Immediate cause of death	Duration
Cardiac + Respiratory Failure	6 days.
Due to Atelectasis	2 days.
Due to Auricular Fibrillation	6 days.
Due to Malignant Cell Hemopneumothorax	"
Other Conditions A. S. C. V. D.	"
Bronchogenic Carcinoma	

(Include pregnancy within 3 months of death)

Date of operation Jan. 30, 1948

Major findings of operation: Bronchogenic Carcinoma with metastasis to pleura, atelectasis

of autopsy:

PHYSICIAN
Underline the disease to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Pere M. D.
Address Mercy Hosp. Date signed 2-6-48

VS 139

59916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G59916

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Louisiana (Md.) (b) County Orleans 15
(c) City or town (Baltimore) Algiers
(If outside city or town limits, write RURAL and give town)
(d) Street No. (Anchorage- 822- S. Broadway) 938 Kitarondt Court
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT Robert GAUBERT

3 (b) If veteran, name war

3 (c) Social Security Account No. 433-14-9259

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 5, 1906

8. AGE: Years	Months	Days	If less than one day
41 (42)	9	12	hr. min.

9. Birthplace Louisiana (Town, county, and state)
10. Usual Occupation Boatswain
11. Industry or business Merchant Marine

FATHER
12. Name George Gaubert
13. Birthplace Louisiana

MOTHER
14. Maiden Name Florence Morcoq
15. Birthplace Louisiana

16 (a) Informant Mrs. Annette Bowers - Sister
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9th-48 (month) (day) (year)
(c) Cemetery or crematory McDonogh Cem.
Location New Orleans La

18 (a) Funeral director Geo L Boyer Jr
(b) Address 1512 Hollins St

19 FEB 7 - 1948 (Date rec'd by registrar) (b) Turnington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 17, 1948, at 4.40 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull & intra-cranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 2/3

(a) Date of injury 1-17-48 about 4 P.M.
(b) Where did injury occur? anchorage- 822 S. Broadway Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury? Fell down steps-found outside

23. Signature Earl L Voyles M.D. Medical Examiner
Date signed 1-19-48

VS 151

X

59917

BC: 48-02287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. 59917

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lafayette & Johns St.

(c) Hospital or institution: Hospital for Women of Md.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3443 Reisterstown Rd.
(If rural give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Rubin (Sheridan York Rubin)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1948

8. AGE: Years | Months | Days: 1 | If less than one day: 23 hr. 48 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business —

FATHER

12. Name Leon Martin Rubin

13. Birthplace Lawrence, Mass.

MOTHER

14. Maiden Name Beatrice Rose Nemzer

15. Birthplace Chelsea, Mass.

16 (a) Informant Mrs. Leon M. Rubin

(b) Address 3443 Reisterstown Rd. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/48. (month) (day) (year)

(c) Cemetery or crematory Arlington

Location Balto. Md.

18 (a) Funeral director Harris Sonnenreich & Son

(b) Address 1822 Eutaw place

19 (a) FEB 7 1948 (Date rec'd by registrar) (b) Hunter for Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1948, at 2 3/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 3, 1948 to Feb. 5, 1948 and that I last saw h[illegible] alive on Feb. 5, 1948

Immediate cause of death	Duration
Anoxemia	
Due to Congenital pneumonia	47 3/4 hrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature H. G. Spencer, Jr. M. D.

Address Hosp. for Women of Md. Date signed Feb 5 48

VS 150

X

G59918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G59918

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 76
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. City Hospital Infirmary
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HERMAN Luken

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Barbara M. Luken
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Feb 21 1870

8. AGE: Years	Months	Days	If less than one day
77 78	11	16	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Herman Luken
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Barbara M. Luken
(b) Address 1695 Darley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9, 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director H. Sander & Sons
(b) Address Baltimore Md.

19 (a) FEB 7 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1948, at 1.30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar pneumonia

Due to

Other Conditions Fracture left Hip

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following: 26/12

(a) Date of injury 2-1-48 at about 10 a. M.
(b) Where did injury occur? City Hospital Infirmary Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell to floor

23. Signature [signature] M.D. Medical Examiner.
Date signed 2-6-48

VS 131

G59919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G59919 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2901 Eastern Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2901 Eastern Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clinton Edgar Waters

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Minnie E. Waters
6 (c) If alive, give age: 65 years
7. Birth date of deceased (mo., day, yr.): May 25 1874
8. AGE: Years 73 | Months 8 | Days 10 | If less than one day: hr. min.
9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual Occupation: Plumber
11. Industry or business

FATHER
12. Name: Frank Waters
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Rosalie Miller
15. Birthplace: Maryland

16 (a) Informant: Mrs. Minnie E. Waters
(b) Address: 2901 Eastern Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9 (1948) (month) (day) (year)
(c) Cemetery or crematory: Trinity
Location: Baltimore Md.
18 (a) Funeral director: H. Sander & Sons.
(b) Address: Baltimore Md.
19 (a) FEB 7 - 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1948, at 1 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1947 to Feb 5 1948 and that I last saw him alive on Feb 4 1948.

Immediate cause of death	Duration
Arteriosclerotic C.V Disease	
Chr Myocarditis	
Due to Cebro Vascular Embolism	1-10-47
Congested Failure	2-1-48
Due to	
Other Conditions None.	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Earl Schumacher M. D.
Address 842 E Eastern Ave Date signed 2-6-48

VS 150

X

BUNS

059920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 059920

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 Cornell St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 Cornell St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Buns

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	married

6 (b) Name of husband or wife Wm. Buns
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22-1913

8. AGE: Years	Months	Days	If less than one day
34	4	13	hr. min.

9. Birthplace Va
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Alfred Smith
13. Birthplace Va

MOTHER
14. Maiden Name Bettie Secato
15. Birthplace Va

16 (a) Informant Mary Coates
(b) Address 600 Cornell St

17 (a) Burial (b) Date thereof Feb 7-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Keller's
Location Accomac Co. Va

18 (a) Funeral director James A Lowe
(b) Address 142 Wolfe St

19 (a) FEB 7 - 1948 (b) Filing for Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5 1948 at 12.00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28 1948 to Feb 5 1948 and that I last saw Resd alive on Feb 5 1948

Immediate cause of death Nephritis and Cardiovascular Disease — Duration (7)
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Jno S Dulaney Jr. M.D.
Address 511 N. Schroeder Date signed 2/7/48

V S 150

X

G59921
4 S 0286

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G59921
Registered No.

CERTIFICATE OF DEATH 157E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Med Exams Case Released to Hosp.
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Paoli
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 Crescent Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Jacobs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-3-42

8. AGE: Years 5 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace Pa
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Lloyd Jacobs
13. Birthplace Pa.

MOTHER
14. Maiden Name Ella Smith
15. Birthplace Pa

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 2-7-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Paoli Pennsylvania

18 (a) Funeral director Williams J. Schleger & Son Inc.
(b) Address Easton Rd. Abington (or) Balto Md.

19 (a) Filed Feb 9 1948 Registrar Huntingdon Valley, Pa.
(Date filed by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7, 1948, at 9 57 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1948 to Feb 7 1948
and that I last saw h[illegible] alive on Feb 7 1948.

Immediate cause of death Cardiac failure — Duration Sudden
Due to Congenital Malformation of Heart
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Feb 4 1948
Major findings of operation: Transposition of Great Vessels
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James D Carmichael M. D.
Address Johns Hopkins Hosp Date signed 2-9-48

To be approved by Dr Maldes

G59922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a

Registered No. G59922

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 Stricker St
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Hall.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F. | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 10, 1934

8. AGE: Years 14 | Months - | Days 25 | If less than one day ... hr. ... min.

9. Birthplace md. (Town, county, and state)

10. Usual Occupation School Girl

11. Industry or business

FATHER
12. Name albert Hall
13. Birthplace md

MOTHER
14. Maiden Name Edna Holt
15. Birthplace md

16 (a) Informant Edna Hall
(b) Address 1514 N. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-48 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location md

18 (a) Funeral director George E. Nelson
(b) Address 1303 Presstman St

19 (a) 2-1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/5/1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19-1948 to 2/5/1948 and that I last saw h.[illegible] alive on 2/5/1948

Immediate cause of death: Teratoma of Rt ovary
Complications to date
Duration
Disseminated
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Extensive Metastasis.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address Provident Hosp. Date signed 2/8/48 M.D.

VS 150

X

G59923 ✓ G59923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Sinai Hospital
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) 23

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2406 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CAPLAN, JOSEPH, (DR)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Esther Nee Gold
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1899

8. AGE: Years	Months	Days	If less than one day
48	5 6	7	hr. min.

9. Birthplace Berkley Va (Town, county, and state)
10. Usual Occupation
11. Industry or business Physican

FATHER
12. Name Simon Caplan
13. Birthplace Russia

MOTHER
14. Maiden Name Rachel Glassner
15. Birthplace Russia

16 (a) Informant Mrs Esther Caplan
(b) Address 2406 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof February 9, 1948 (month) (day) (year)
(c) Cemetery or crematory Norfolk Va
Location Virginia

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) FEB 8 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 Feb 1948, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 Feb 1948 to 7 Feb 1948, and that I last saw h l alive on 7 Feb 1948

Immediate cause of death: Gastro-intestinal hemorrhage
Due to: Bleeding duodenal ulcer
Due to:
Other Conditions: Hypernephroma
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: above

Duration
several yrs
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Marvin W. Dann M. D.
Address Sinai Hosp Date signed 2-24-48

VS 150

117B

G59924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G59924

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5102 Litchfield Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5102 Litchfield

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Jacob Goldberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Russia

(Town, county, and state)

10. Usual Occupation

11. Industry or business Laborer

FATHER

12. Name Goldberg

13. Birthplace Russia

MOTHER

14. Maiden Name Unknown

15. Birthplace Russia

16 (a) Informant Morris Goldberg

(b) Address 5102 Litchfield Ave

17 (a) Burial (b) Date thereof Feb 9/48

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Hebrew Rosedale Cemetery

Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124-26 W. North Ave

FEB 8 - 1948

(Date rec'd by registrar)

(b) Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1948, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to Feb 7 1948 and that I last saw him alive on Feb 7 1948.

	Duration
Immediate cause of death Congestive Heart Failure	6 mos.
Due to Arteriosclerotic Heart Disease	4 yrs.
Due to	
Other Conditions Hypertrophy Prostate Benign (Include pregnancy within 3 months of death)	1 yr.

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Nyeton I. Lawman M. D.

Address 4643 Park Heights Ave Date signed 2-7-48

VS 190

G59925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 461

G59925
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City #16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3338 Piedmont Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max Saltzman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Dora
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1878

8. AGE: Years	Months	Days	If less than one day
70 69			hr. min.

9. Birthplace Europe
(Town, county, and state)

10. Usual Occupation

11. Industry or business Used Furniture

FATHER
12. Name Reuel Saltzman
13. Birthplace Europe Russia

MOTHER
14. Maiden Name Dora ?
15. Birthplace Europe Russia

16 (a) Informant Dora Saltzman
(b) Address 3338 Piedmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 8, 1948 (month) (day) (year)
(c) Cemetery or crematory Beth Hamedrosh Hag
Location Old Phila. Road, Rosedale

18 (a) Funeral director Sol. Levinson & Bros.
(b) Address 1124 26 W. North Ave.

19 (a) FEB 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 February 1948, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4 Feb. 1948, to 6 Feb 1948, and that I last saw him alive on 6 Feb 1948.

Immediate cause of death	Duration
Cardiac failure	
Carcinoma of rectum Tr.	
Due to intestinal obstruction	
Due to	
Other Conditions Arteriosclerotic C-V disease	
(Include pregnancy within 3 months of death)	

Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D. Rosin M. D.
Address West Balt. Gen. Hosp. Date signed 6 Feb 48

VS 150

G59926

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 108

G59926
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 214 N. Stricker Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 214 N. Stricker Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME McCAULLEY STANCIL

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	married

6 (b) Name of husband or wife Irma Stancil
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1918

8. AGE: Years	Months	Days	If less than one day
30			hr. min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual Occupation Weder
11. Industry or business Md Dry Dock

FATHER
12. Name Robert Stancil
13. Birthplace North Carolina

MOTHER
14. Maiden Name Maggie Sneed
15. Birthplace North Carolina

16 (a) Informant Irma Stancil
(b) Address 214 N. Stricker St

17 (a) Burial (b) Date thereof Feb 10-1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sneed Grove Cem.
Location Ellerbe N. C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley ave Lumberton North Carolina

FEB 8 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH February 6 1948, at 11:40 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner
Date signed 2-6-48

VS 151

X

G59927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

G59927 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 E Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Harris.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-1-86

8. AGE: Years 61 | Months 10 | Days 5 | If less than one day hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Edward Harris
13. Birthplace N. C.

MOTHER
14. Maiden Name Alice Brown
15. Birthplace N. C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/48 (month) (day) (year)
(c) Cemetery or crematory Ashley Grove
Location Youngsville, N. C.

18 (a) Funeral director Elroy A. Watson
(b) Address 1000 Bloomsbury Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1- 1948, to Feb. 6 1948, and that I last saw him alive on Feb. 6 1948.

	Duration
Immediate cause of death Coronary occlusion	5 Min.
Due to Thrombosis	
Due to	
Other Conditions Hypertensive cardiovascular disease	Many years

(Include pregnancy within 3 months of death)

Date of operation 2-4-48

Major findings of operation: Cancer of Prostate

of autopsy: Same; coronary occlusion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Perry B. Hudson M. D.
Address Johns Hopkins Date signed 2-6-48

VS 150

93D

G59928 ✓ G59928
GM. 97301

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 110B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2117 Walbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy R. Cline

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife William D.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12 - 1879

8. AGE: Years	Months	Days	If less than one day
68	9	24	hr. min.

9. Birthplace MD. (Balto. Co.,)
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business --

FATHER
12. Name Ruben Zimmerman
13. Birthplace MD.

MOTHER
14. Maiden Name Harriet Shotrow
15. Birthplace ILL.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave

17 (a) Burial (b) Date thereof 2/9/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address Baltimore, Md.

19 (d) FEB 8 - 1948 Thurlington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 6 - 1948, at 2.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11 - 14 - 1945 to Feb. 6 - 1948, and that I last saw her alive on 2 - 6 - 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Chronic fibrous pleuritis, Partial atelectasis	
Due to	
Other Conditions Osteoarthritis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. T. Benford M. D.
Address Balt. City Hosp. Date signed 2-6-48

VS 150

59B

G59929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G59929
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4301 Gelston Dr.
(c) Hospital or institution: --
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) --

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4301 Gelston Dr.
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME HENRY WILLIAM VOGT

3 (b) If veteran, name war ***
3 (c) Social Security Account No. ***

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Annie R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1860

8. AGE: Years	Months	Days	If less than one day
87	6	1	hr. min.

9. Birthplace Beaver Co., Pa.
(Town, county, and state)
10. Usual Occupation Butcher
11. Industry or business Self

FATHER
12. Name Jacob Vogt
13. Birthplace Germany

MOTHER
14. Maiden Name --
15. Birthplace --

16 (a) Informant Mrs. Geo. Alt.
(b) Address 6 Holmehurst Ave., Catonsville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves; Balto., Md.

19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1948 19 , at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1948 to Feb 4 1948, and that I last saw him alive on Feb 4 1948.

Immediate cause of death	Duration
Coronary Occlusion	Sudden
Due to Cardio Vascular Renal	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Glassman M.D.
Address 753 W. Fayette Date signed Feb 7 1948

FEB 8 1948

X

G59930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G59930 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 W. Rogers Ave.
(c) Hospital or institution:
Home for the Aged of the Methodist Church
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 87 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 W. Rogers Ave.
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME JAMES A. LEAGUE

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Minnie Andrew League
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1860

8. AGE: Years	Months	Days	If less than one day
87	5	29	hr. min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business --

FATHER
12. Name William J. League
13. Birthplace Balto., Co; Md.

MOTHER
14. Maiden Name Susan Carback
15 Birthplace Balto., Co; Md.

16 (a) Informant Miriam O. Coates -- Supt.
(b) Address 2211 W. Rogers Ave.

17 (a) Burial (b) Date thereof 2/9/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Greenmount
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Fa. Aves; Balto., Md.

19 (a) (Signature) for Williams M.D. Registrar
(Date rec'd by registrar) FEB 8 1948

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MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6, 1948 19 , at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 19 48 to Feb 6 1948, and that I last saw him alive on Feb 6 19 48.

Immediate cause of death	Duration
Myocardial Insufficiency	6 days
Due to Arteriosclerosis	20 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur J Dana M. D.
Address 800 W 32nd St Date signed 2/9/48

X

G59931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G59931

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2211 W. Rogers Ave.

(c) Hospital or institution: Home for Aged & M.E. Church

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 81 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2211 W. Rogers Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME ALMIRA JOSEPHINE GEES

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1866

8. AGE: Years	Months	Days	If less than one day
81	7	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name B. Franklin Gees

13. Birthplace York, Pa

MOTHER

14. Maiden Name Mary Ann Slicer

15. Birthplace Balto., Md.

16 (a) Informant Miss Miriam O. Coates, Supt.

(b) Address 2211 W. Rogers Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Cem.

Location Balto., Md.

18 (a) Funeral director WILLIAM J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) FEB 9 1948 (Date rec'd by registrar) (b) Huntington, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7, 1948, at 1:45a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1948 to Feb 6 1948. and that I last saw h[illegible] alive on Feb 6 1948.

	Duration
Immediate cause of death Cerebral hemorrhage	2 days.
Due to uterine sclerosis	20 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Arthur J. Dann M. D.

Address 800 W 32nd St Date signed 2-7-48

VS 150

X

G59932

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G59932
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3020 Presstman St.
(c) Hospital or institution:

14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3020 Presstman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES HENRY NESBITT

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1872

8. AGE: Years	Months	Days	If less than one day
75	7	21	hr. min.

9. Birthplace Balto.
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business retired

FATHER
12. Name Jonathan Nesbitt
13. Birthplace Richmond, Va.

MOTHER
14. Maiden Name Virginia Ramkey
15. Birthplace Richmond, Va.

16 (a) Informant Mrs. Mary N. Bauer
(b) Address 3020 Presstman St.

17 (a) Burial (b) Date thereof 2/9/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 8 1948 (b) Huntington Williams M.D. Registrar
(Date filed by registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6, 1948, at 2:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947 to Feb 6 1948.
and that I last saw him alive on Feb 6 1948.

Immediate cause of death	Duration
Myocarditis	about 3 mo.
Due to Advanced arteriosclerosis	?
Due to Hypertension	?
Other Conditions Anemia (secondary)	about 3 mo.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter Dibbett M. D.
Address 220 Harrison Blvd Date signed Feb 7/48

659933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

659933 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 611 N. Augusta Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 611 Augusta Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Bagnall

3 (b) If veteran, name war: World I

3 (c) Social Security Account No. 215-24-8749

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Eva. Worth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4 1878

8. AGE: Years 69 | Months 5 | Days 3 | If less than one day: hr. min.

9. Birthplace Corning, N.Y. (Town, county, and state)

10. Usual Occupation Retired U.S. Army

11. Industry or business

FATHER
12. Name Robert Grant Bagnall
13. Birthplace Glascow, Scotland

MOTHER
14. Maiden Name Amanda Meyer
15. Birthplace Bremen, Germany

16 (a) Informant Mrs. William F. Holmes
(b) Address 611 Augusta Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/48 (month) (day) (year)
(c) Cemetery or crematory Arlington National
Location Arlington, Va.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 (a) 2-9-1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 Feb. 1948, at 8:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Hammer Jr. M.D. Medical Examiner.
Date signed 7 Feb. 48

VS 191

G59934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

467

G59934
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2207 Linden Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-d
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2207 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Freda R. Myers

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Louis J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER — 12. Name	Sadick
13. Birthplace	Russia
MOTHER — 14. Maiden Name	Sarah
15. Birthplace	Russia

16 (a) Informant Louis J. Myers
(b) Address 2207 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-8-48 (month) (day) (year)
(c) Cemetery or crematory Oak Hill Israel
Location Southern Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2460 Eutaw Place

19 FEB 8 1948 (Date rec'd by registrar) Livingston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-6-1948 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1947 to 2-6 1948, and that I last saw her alive on 2-6 1948.

Immediate cause of death	Duration
Carcinoma of Rectum	2 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 1 day ago
Major findings of operation: Carcinoma Resectum
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Lachman M. D.
Address 2322 Eldorado Ave Date signed Feb 7, 1948.

VS 150

X

C59935 BALTIMORE CITY HEALTH DEPARTMENT C59935
CERTIFICATE OF DEATH 74a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2 Greenspring Ave
(c) Hospital or institution: Levindale 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 128 So Regle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Gospe

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Joseph
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1863
8. AGE: Years 85 Months Days If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Harry
13. Birthplace Russia

MOTHER
14. Maiden Name Jessie
15. Birthplace Russia

16 (a) Informant Levindale Home
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-8-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place
Herrington Williams, M.D.

19 (a) FEB 8 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7th 1948, at 3:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1948 to Febr. 7 1948, and that I last saw her alive on Febr. 6th 1948.

Immediate cause of death: Lymphatic Leucemia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Jerome J. Rhoneberg M. D.
Address Levindale Hebrew Home Date signed 2/7/48

VS 150

G59936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8 3a

G59936

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4613 Park Heights Ave

(c) Hospital or institution: Mt Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 45yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2014 E. Balto St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Heyman Snyder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Abraham

13. Birthplace Russia

MOTHER

14. Maiden Name Anna

15. Birthplace Russia

16 (a) Informant Bessie Snyder

(b) Address 2014 E Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-8-48 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Philadelphia Rd-Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 2100 Eutaw Place

19 (a) FEB 9 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-7- 1948, at 6P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-4 1948 to 2-7 1948, and that I last saw him alive on 2-7 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Dannie J. Abernathy M. D.

Address 2320 Eutaw Place Date signed 2/8/48

VS 150

X

G59937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G59937 Registered No. 46a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Bridway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 20 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Florida (b) County:
(c) City or town: Tallahassee (If outside city or town limits, write RURAL and give town)
(d) Street No.: 702 W. St. Augustine St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Mrs. Mary E. Jones

3 (b) If veteran, name war: | 3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife: Mr. Wm. Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-12-84

8. AGE: Years	Months	Days	If less than one day
53	11	25	hr. min.

9. Birthplace: Tallahassee, Florida (Town, county, and state)
10. Usual Occupation: housewife
11. Industry or business:

MOTHER | FATHER
12. Name: John Clemons
13. Birthplace: Florida
14. Maiden Name: Fannie Finney
15. Birthplace: Florida

16 (a) Informant: Mrs. Wilhelmina Tapp
(b) Address: 610 N. Bridway, Balto.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb. 8/48 (month) (day) (year)
(c) ~~Cemetery or crematory~~ Tallahassee Fla.
Location:

18 (a) Funeral director: Harry H. Linkhe
(b) Address: 4101 E. Edmondson Ave.

19 (a) FEB 9 1948 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1948, at 3:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-29- 1947 to 2-7- 1948 and that I last saw her alive on 2-7- 1948.

Immediate cause of death	Duration
Carcinoma of esophagus. (operation 12-15-47)	2 years.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 12-15-47
Major findings of operation: Carcinomatosis
of autopsy: 2-7-48 Carcinomatosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: J. J. Graham M. D.
Address: Church Home Date signed 2-7-48 M. D.

X

G59938

BC - 48 - 05220

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

G59938
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green St.
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3138 Yo-Kway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Ulsch

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: S.
6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 5, 1948

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Wm. S. Ulsch Sr.
13. Birthplace Md.

MOTHER
14. Maiden Name Ruth Newcomb
15. Birthplace Md.

16 (a) Informant Wm L. Ulsch Sr.
(b) Address 3138 Yorkway Dundalk

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 7 1948 (month) (day) (year)
(c) Cemetery or crematory Dundalk Bridge.
Location Pikesville.

18 (a) Funeral director Shoemyth & Donovan.
(b) Address 345-47 Chestnut Ave.

19 (a) Date received 1948 (b) Registrar Arlington Williams M.D. Registrar

FEB 8

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/7 19 48, at 8 10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 5 19 48 to 7 Feb 19 48
and that I last saw him alive on 7 Feb 19 48.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Atelectasis Pneumonetis	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clarence W. Martin M. D.
Address Univ. Hosp. Date signed 2-9-48

X

G59939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G59939 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution: Redwood & Green Sts. 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 775 W. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abicht Lydia K. Abicht

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1888

8. AGE: Years	Months	Days	If less than one day
59	1	9	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Late Charles M. Abicht
13. Birthplace Germany

MOTHER
14. Maiden Name Late Charlotte Voigt
15. Birthplace Germany

16 (a) Informant Miss Laura C. Abicht
(b) Address 775 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9/48. (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry A. Hubble
(b) Address 4101 Edmondson Ave.

19 (a) FEB 8 1948 (Date received by registrar) (b) Harrington Williams, Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-6 1948, at 8 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-23 1948, to 2-6 1948, and that I last saw her alive on 2-5 1948.

Immediate cause of death [redacted]
Coronary occlusion — Duration

Due to

Due to

Diabetes mellitus Uncontrolled
Other Conditions Chr. Pyelonephritis + Arteriosclerosis
Gen. Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. L. Jamison M. D.
Address Univ. Hosp. Balto, Md. Date signed 2-6-48

94a

G59940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1319

G59940 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 524 Normandy Ave/
(c) Hospital or institution: 20-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 524 Normandy Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Becker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife F. Milton Becker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1883.

8. AGE: Years	Months	Days	If less than one day
64	4	4	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Milton Cover
13. Birthplace Md.

MOTHER
14. Maiden Name Lillie Freeze
15. Birthplace Md.

16 (a) Informant Mr. F. Milton Becker
(b) Address 524 Normandy Ave.

17 (a) Burial (b) Date thereof Feb. 9/48.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount Ave. & Oliver Sts

18 (a) Funeral director Harry A. Meitzke
(b) Address 4101 Edmondson Ave.

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5/48 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 19 , to 2-5 1948 and that I last saw h alive on 2-5 19 48.

Immediate cause of death: Cerebral hemorrhage — Duration.
Due to: Chronic nephritis — Sclerosis & hypertension
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place) H. W. SCHEYE
(e) Means of injury
23. Signature M. D.
Address 3921 Edmondson Date signed

VS 150

2-7-48

G59941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G59941
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 632 N. Augusta Ave.
(c) Hospital or institution: 16-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 632 N. Augusta Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter J. Satterfield

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Late Lillian V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1860.

8. AGE: Years 87 | Months 7 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Andrew Satterfield
13. Birthplace Unknown

MOTHER
14. Maiden Name Marietta ---------
15. Birthplace Unknown

16 (a) Informant Claude M. Satterfield
(b) Address 632 N. Augusta Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry A. Kutzke
(b) Address 4101 Edmondson Ave.

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6/48. 19... at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-4 1946 to 2-6 1948, and that I last saw him alive on 2-6 1948

Immediate cause of death: acute heart failure — Duration
Due to arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at ... M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. D. Wolfkeyl M. D.
Address 324 Edmondson Date signed 2-7

VS 150

X 1948

G59942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G59942

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St 10-1
(c) Hospital or institution:
Home For The Aged Town
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 N. Valley
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Rider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26, 1858

8. AGE: Years	Months	Days	If less than one day hr.	min.
79	10	13		1868

9. Birthplace Emmitsburgh Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frederick Rider
13. Birthplace

MOTHER
14. Maiden Name Lucy Wise
15. Birthplace

16 (a) Informant Sister Sisters of The Poor
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Feb 9/48 (month) (day) (year)
(c) Cemetery or crematory Emitsburg Md
Location

18 (a) Funeral director J. Kleinhammer Sons
(b) Address 426 W. Monument

19 (a) (Date rec'd by Registrar) **(b)** (Registrar)

FEB 8 1948 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5 1948, at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-16 1947 to Jan 8 1948 and that I last saw her alive on Dec 7 1948.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic Myocarditis	2 yrs
Due to	
Other Conditions Arterio Sclerosis	5 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E North Ave **Date signed** 2/8/48

X

(59943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 59943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Riderswood
(If outside city or town limits, write RURAL and give town)
(d) Street No. Sherwood Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Dr. Burton E. Livingston

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Marguerite A. Livingston
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-9-75

8. AGE: Years	Months	Days	If less than one day
73	11	29	hr. min.

9. Birthplace Mich. (Town, county, and state)
10. Usual Occupation Professor (Retired)
11. Industry or business

FATHER
12. Name Benjamin Livingston
13. Birthplace N. Y.

MOTHER
14. Maiden Name Keziah Lincoln
15. Birthplace Mich

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremation (b) Date thereof Feb. 10, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto., Md.

18 (a) Funeral director Landon M. Bowles
(b) Address Govans, Md.

19 (a) FEB 9 1948
(Date rec'd by registrar) Huntington Williams Asst. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 24 1947 to Feb 8 1948 and that I last saw h[illegible] alive on Feb. 5 1948.

Immediate cause of death	Duration
Left ventricular failure	2 hrs
Due to Arteriosclerotic heart disease	10 yrs.
Due to	
Other Conditions Hyperkeratosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Moderately enlarged heart

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Martin Myers, Jr. M.D.
Address Johns Hopkins Hosp. Date signed Feb 9, 1948

VS 150

G59944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G59944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 653 W LOMBARD St.
(c) Hospital or institution: 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 653 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? ~~Md.~~ (Yes or No)
If yes, name country

3 (a) FULL NAME GUY BOYER

3 (b) If veteran, name war: 1st WORLD WAR
3 (c) Social Security Account No. 219-03 6579

4. Sex: M
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED.
6 (b) Name of husband or wife: BLANCH BOYER.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 3, 1892
8. AGE: Years 55 | Months 7 | Days 3 | If less than one day hr. min.
9. Birthplace Odenton Md (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name William F. Boyer
13. Birthplace Severn, Anne Arundel County Md

MOTHER
14. Maiden Name Jannie Gardner
15. Birthplace Severn, Anne Arundel County Md.

16 (a) Informant Blanch Boyer
(b) Address 653 W. Lombard St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Frederick Ave. Balto.
18 (a) Funeral director Howard N. Bligh & Sons
(b) Address 1600 Belair Rd.
19 (d) FEB 9 1948 (Date rec'd by registrar) (by) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6/48 19 , at 10 M
21. I certify that death occurred on the date above stated; that I attended deceased from 2/4/48 19 , to 2/5/48 19 , and that I last saw h[illegible] alive on 2/6/48 19 .

Immediate cause of death	Duration
Acute Myocarditis	
Due to Cancer of Stomach	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature William F Boyer
Address Fair Edmondson Date signed 2/7/48 M.D.

V S 150

59945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. 59945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2131 W. Saratoga St
(c) Hospital or institution: 20-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2131 W. Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Albert Courtney

3 (b) If veteran, name war None
3 (c) Social Security Account No. 213-10-7957

4 Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) January 24 1905
8. AGE: Years 43 Months 0 Days 13 If less than one day hr. min.
9. Birthplace Washington D.C. (Town, county and state)
10. Usual Occupation Brush Maker
11. Industry or business

FATHER
12. Name George A. Courtney
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Edna M. Elwell
15. Birthplace Virginia

16 (a) Informant Edna M. Courtney
(b) Address 2131 W. Saratoga St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-1948 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto Co. B.M. Walker
18 (a) Funeral director Pratt & Stricker Sts
(b) Address
19 (a) FEB 9 - 1948 (Date rec'd by registrar) (b) Huntington Avenue

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6, 1948, at 2A M
21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 18 1946 to Feb 6 1948 and that I last saw him alive on Feb. 5 1948.

	Duration
Immediate cause of death: cerebral embolysm	4 days
Due to: rheumatic heart disease	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature George A Knop
Address 3030 Edmondson Date signed 2/6/1948 M.D.

VS 150

159946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 59946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 927 Plum St
(c) Hospital or institution: 23-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 927 Plum St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Fisher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Wm. Fisher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
72 71			hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation at Home
11. Industry or business

FATHER
12. Name Alexander Netter
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Robinson
15. Birthplace Va.

16 (a) Informant William Fisher
(b) Address 927 Plum St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A Hayes
(b) Address 1142 Wood St

FEB 9 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4 1948 at 3.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 28 1947 to Feb 4 1948 and that I last saw h[illegible] alive on Feb 4 1948.

Immediate cause of death [illegible] Duration 6 hours
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hubert L Watts M.D.
Address 15 E Lexington Date signed 2/6/48

V S 150

X

59947
AB-89562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 59947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 261
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5622 Greenhill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Hughes

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Wid.

6 (b) Name of husband or wife: Quincy (D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 19- 1874

8. AGE: Years: 73 | Months: 2 | Days: 19 | If less than one day: hr. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Frederick Ibbott or I hhot(D
13. Birthplace: England

MOTHER
14. Maiden Name: Mary ? (D
15. Birthplace: Md.

16 (a) Informant: Records-Baltimore City Hospitals
(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2/10/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore MD
Location: Baltimore MD

18 (a) Funeral director: Thomas Col Fe
(b) Address: 1217 E Cont St

19 (a) FEB 9 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 1948, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-28 1944, to 2-6- 1948, and that I last saw her alive on 2-6 1948.

Immediate cause of death [redacted]
Bronchopneumonia, Duration: 3 wks
Due to Cerebrovascular accident, Duration: 3 yrs
Due to Generalized Arteriosclerosis, Duration: yrs
Other Conditions (D (Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Anatomic

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: J C Robinson Jr. M. D.
Address: Balt. City Hosp. Date signed: 2/7/48

659948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 107

659948 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 522 N. LINWOOD AVE
(c) Hospital or institution: 7-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 522 N. LINWOOD AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BEVERLY L. WILSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/7/1947

8. AGE: Years	Months	Days	If less than one day
	2	1	hr. min.

9. Birthplace COLUMBIA S. CAROLINA
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name LOUIS C. WILSON
13. Birthplace MARYLAND

MOTHER
14. Maiden Name EVA BRECKELL
15. Birthplace ENGLAND

16 (a) Informant LOUIS C. WILSON
(b) Address 522 N. LINWOOD AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/9/48 (month) (day) (year)
(c) Cemetery or crematory PARKWOOD
Location TAYLOR AVE

18 (a) Funeral director WM COOK INC.
(b) Address 1217 ST. PAUL ST.

19 (a) FEB 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 Feb 1948, at 7 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Rogers M.D.
Medical Examiner
Date signed 8 Feb 48

VS 181

659949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1314

Registered No. 659949

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Gertrude Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Rosemont
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3020 Louisiana Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. McDaniel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ John R. McDaniel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 27th 1862

8. AGE: Years	Months	Days	If less than one day
85	10	10	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name ? Williams
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Robert V. Cook
(b) Address 3020 Louisiana Ave Rosemont

17 (a) Burial (b) Date thereof 2/10/48
(Burial, ~~cremation~~, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Mt. Carmel
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 FEB 9 - 1948 (Date rec'd by registrar) Huntington Williams (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7th 1948, at 5.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 11 1946 to Feb 7 1948 and that I last saw her alive on Feb 6 1948

Immediate cause of death	Duration
Chronic Nephritis	
Due to	
Due to	
Other Conditions Chronic Myocarditis Hypertension Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Lansdowne R 7 Box [illegible] Date signed 2/8/48

VS. 150

059950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. 059950

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave. & Madison St.
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 56 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) ~~City or~~ town Cockeysville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Masonic Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN P. KRAFT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Mary Kraft
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 8th 1872

8. AGE: Years	Months	Days	If less than one day
75	10	28	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Blacksmith

FATHER
12. Name Conrad Kraft
13. Birthplace Germany

MOTHER
14. Maiden Name Regina Bierleim
15. Birthplace Germany

16 (a) Informant Laura M. Schroeder
(b) Address Masonic Home

17 (a) Burial (b) Date thereof 2/10/48
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Schwartz
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) FEB 9 1948 (b) Washington Blvd. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 1948, at 5.26 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 3 1948, to Feb. 6 1948, and that I last saw him alive on Feb. 6 1948.

Immediate cause of death	Duration
Hypostatic pneumonia	3 days
Due to Leukemia, chronic, lymphatic	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alfred H. Damm M. D.
Address Maryland General Hosp. Date signed 2/6/48

G59951

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 194a

Registered No. G59951

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43 days
(e) Length of stay in Baltimore (yrs., mos., or days) 29 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 14 E. Chase St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander C. Matheson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27, 1879

8. AGE: Years	Months	Days	If less than one day
68	9	11	hr. min.

9. Birthplace Ala. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unknown.
13. Birthplace

MOTHER
14. Maiden Name Unknown.
15. Birthplace

16 (a) Informant Herman J. Hausser
(b) Address May Meadows, Va.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/48 (month) (day) (year)
(c) Cemetery or crematory May Meadows, Va
Location
18 (a) Funeral director John O. Mitchell & Sons Inc
(b) Address 190 Eutaw Street Huntington Williamsport, Md.
19 (a) FEB 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1948 at 1.02 P.M
21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 3 1948 to Feb. 8 1948, and that I last saw him alive on Feb. 8 1948

	Duration
Immediate cause of death: Coronary Occlusion	Sudden.
Due to: Coronary Arteriosclerosis	3 Years.
Due to:	
Other Conditions: Diverticulosis of Colon	P

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Alfred K. Dann M. D.
Address Maryland General Hospital Date signed 2/8/48

VS 150

G59952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓107

Registered No. G59952

BC=68452

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St. Joseph's W-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 525 S. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Myers ✓

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 7-22-47

8. AGE: Years	Months	Days	If less than one day
	6	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Thomas Myers Jr
13. Birthplace Bap Frederick Md

MOTHER
14. Maiden Name MARY ANN FOSTER
15. Birthplace Camden, Md.

16 (a) Informant Thomas Myers
(b) Address 525 S Charles St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/9/48 (month) (day) (year)
(c) Cemetery or crematory - CEDAR HILL
Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F. DEANY, INC
(b) Address 715 LIGHT ST -30

19 (a) FEB 9 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-6 1948, at 1.25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/2 1948 to 2/6 1948 and that I last saw him alive on 2/6 1948.

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E May M. D.
Address 1400 N. Caroline St Date signed 2/6/48.

V S 150

G59953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1048

G59953 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 23-3
(b) Street address
(c) Hospital or institution: South Baltimore Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 Patapsco St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Catherine Drager

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Theodore Drager, Sr.
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1881

8. AGE: Years	Months	Days	If less than one day
66	11	24	hr. min.

9. Birthplace Baltimore, MD
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name — Kent
13. Birthplace Baltimore, MD.

MOTHER
14. Maiden Name Unknown
15. Birthplace Baltimore, MD

16 (a) Informant Mrs. Mary C Thompson
(b) Address 1700 Patapsco St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 10 48 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Frederick Rd

18 (a) Funeral director John F. Denny, Inc.
(b) Address 715 Light St -30

19 (a) FEB 9 1948 (Registered by registrar) (b) Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6, 1948, at 11:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-6 1948 to 2-6 1948.
and that I last saw h[illegible] alive on 2-6 1948

Immediate cause of death Respiratory Failure — Duration 2 hours

Due to Lobar Pneumonia, Left Lower Lobe — Duration 1 week

Due to Bilateral Pyon Bronchiectasis. — Duration 2 weeks

Other Conditions Cystitis, Acute — Duration 3 weeks

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy: 2-7-48

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alex G. Dallas Jr. M. D.
Address SBGH Date signed 2/9/48

VS 150

C59954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No. C59954

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 102 N. Bruce
(c) Hospital or institution: 19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 N. Bruce
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Violet Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife Chas.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4 - 1891

8. AGE: Years	Months	Days	If less than one day
56	4	26	5 hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Henry Johnson
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Nelson
15. Birthplace Md

16 (a) Informant Foster Ward
(b) Address Melfa Va.

17 (a) Burial (b) Date thereof 2-11-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Glen
Location Balto. Co.

18 (a) Funeral director Samuel W. Sullivan Jr.
(b) Address 1011 N. Arlington Ave

19 (a) FEB 9 1948 Arlington Mills
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1948, at 10 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/30/48 to 2/6/48
and that I last saw her alive on 2/5/48 19
Immediate cause of death Cerebral Hemorrhage — Duration 4 Hrs
Due to Hypertension — Duration 6 Yrs
Due to — Duration
Other Conditions — Duration
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. W. Decorse M.D.
Address 110 Eastern Ave Date signed 2/7/48

V S 150

59955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G59955

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1526 N. Payson St
(c) Hospital or institution: 15.2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1526 N. Payson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MORRIS FINE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	WIDOW

6 (b) Name of husband or wife LENG
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name ISADORE
13. Birthplace RUSSIA

MOTHER
14. Maiden Name HILD
15 Birthplace RUSSIA

16 (a) Informant LEON FRANKLE
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-9-48 (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location PHIL. PA. & HAMILTON AVE

18 (a) Funeral director JACK LEWIS INC
(b) Address 2100 EUTAW PL.

19 FEB 9 - 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-8 1948, at 9:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10 1947 to Feb 8, 1948 and that I last saw h.i.m alive on Feb. 8, 1948.

Immediate cause of death	Duration
Uremia	1 week
Due to Carcinoma of Gall Bladder and Liver	6 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ernest Lewis M.D.
Address 1601 N. Broadway Date signed 2/8/48

659956 BC-48-01942 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 157E Registered No. 659956

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dunkland and Rayner Sts.
(c) Hospital or institution:
Mercy Balt. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balt. 28. Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 235 Ruxmoor Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Alan Franklin Santopietro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-25-48

8. AGE: Years | Months | Days | If less than one day 17 hrs. hr. min.

9. Birthplace Balt. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER 12. Name Joseph Santopietro
13. Birthplace Napoli, Italy

MOTHER 14. Maiden Name Hayden Harris
15. Birthplace Louisa, Va.

16 (a) Informant Joseph Santopietro
(b) Address 235 Ruxmoor Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 29 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FC (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 1948, at 4:23 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1948, to Jan 26 1948, and that I last saw him alive on JAN 26 1948.

Immediate cause of death	Duration
Patent Foramen Ovale	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Patent foramen Ovale

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Francis L. Trumbull M. D.
Address Balt. Gen. Hosp. Date signed Jan 26, 1948

VS 150

659957

BALTIMORE CITY HEALTH DEPARTMENT

659957 BC-48-01907 CERTIFICATE OF DEATH 1579 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~Unit~~ 15-2
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1326 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Delores Sligh

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race B

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife Infant

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-17-48.

8. AGE: Years | Months | Days 8 7 | If less than one day hr. min.

9. Birthplace Balti Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

MOTHER / FATHER

12. Name Jane Sligh

13. Birthplace Md.

14. Maiden Name Emma Clement

15. Birthplace Md.

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School JAN 30 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 FEB 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24 1948, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19 1948, to Jan 24 1948, and that I last saw h er alive on Jan. 24 1948.

Immediate cause of death	Duration
Respiratory failure	
Due to Aspiration of vomitus	
Due to inability to swallow because of severe cleft palate	
Other Conditions cleft lip, pneumonia, esophageal stricture	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert C. Hunter M.D.

Address Univ. Hospital Date signed Jan 24 1948

VS 133

X

G59958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G59958

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6011 Falls Road
(c) Hospital or institution: 27-13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6011 Falls Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ella Shipley

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4 Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: James R. Shipley
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 28-1856
8. AGE: Years 91 | Months 11 | Days 9 | If less than one day hr. min.
9. Birthplace Laurel, Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Samuel Thompson
13. Birthplace Maryland

MOTHER
14. Maiden Name Susan Keith
15 Birthplace Maryland

16 (a) Informant Miss Mildred R. Fair
(b) Address 6011 Falls Road
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9-1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland
18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road
19 (a) Filed FEB 9 1948 (b) Registrar Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7- 1948, at 9A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 11 1942 to Feb 7 1948, and that I last saw her alive on Feb 5 1948

Immediate cause of death	Duration
Cardiac failure	1 wk.
Due to Chron. Cardio-Vas- cular disease.	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 1 Mew 3651 - Date signed 2/7/48

VS 130

X

C59959

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

90 B

Registered No. C59959

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 20-3
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U S Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County -
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2007 W. Baltimore St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Moran, William Joseph

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No. 216-12-3037

4. Sex: m | 5. Color or race: w | 6 (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife: ✓

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr) July 27, 1886

8. AGE: Years 61 | Months 6 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William Moran
13. Birthplace Ireland

MOTHER
14. Maiden Name Abbie Denehey
15 Birthplace Ireland

16 (a) Informant Records
(b) Address U S Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/48 (month) (day) (year)
(c) Cemetery or crematory Balto. Natl. Cem.
Location 5301 Frederick Ave.

18 (a) Funeral director John J. Gowan & Son
(b) Address 2403 Hollins St.

19 (a) FEB 9 1948 (Date rec'd by registrar) (b) Registered by Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 19 48 at 5:47PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 6, 19 48 to Feb. 6, 19 48, and that I last saw h im alive on Feb. 6, 19 48.

	Duration
Immediate cause of death Adhesive peri-	
carditis	2 wks.
2-Congestive failure	1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M.D.
Address U S Marine Hospital Date signed 2-7-48

MAYER

G59960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G59960

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2326 W Fayette St
(c) Hospital or institution: D.of A 20-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2326 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John F Mayer.

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife ✓

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1869

8. AGE: Years	Months	Days	If less than one day
78	8	8	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Pattern Maker

11. Industry or business Retired

FATHER 12. Name Anton H Mayer

13. Birthplace Richmond Va.

MOTHER 14. Maiden Name Mary F. Wegenfeld

15. Birthplace Germany

16 (a) Informant Miss Mary C. A. Mayer

(b) Address 2326 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem

Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Gowan & Son

(b) Address 901-03 Hollins St

19 (a) FEB 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/7 1948 at 8:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to Arteriosclerotic C.V. Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature D. P. Salvadori M.D. Medical Examiner.

Date signed 2/7/48

VS 151

G59961

EDWARD

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59961

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — 255
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5412 Pennington Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES Edward RUSSELL

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1936

8. AGE: Years	Months	Days	If less than one day
11	10	2	hr. min.

9. Birthplace Wilmington, N. J. (town, county, and state)
10. Usual Occupation Student Public
11. Industry or business School —

FATHER
12. Name Glen Herman Russell
13. Birthplace Webster Springs, W. Va.

MOTHER
14. Maiden Name Viola Jaunita Lawrence
15. Birthplace Wilmington, N. J.

16 (a) Informant Mrs. Viola Jaunita Russell
(b) Address 5412 Pennington Av. (Mother)

17 (a) Burial — (Burial, cremation, or removal) (b) Date thereof Mon. Feb. 9, 1948 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem.
Location Anne Arundel Co. Md.

18 (a) Funeral director A. Howard Young
(b) Address 3 Charles St. Balto 3, Md.

19 (a) FEB 9 1948 (Date rec'd by registrar) (b) Huntington Williams Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH (day) Feb. 5, 1948, at 6 a. M

21. I certify that I took charge of the remains described above, held an autopsy thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull.
Contusion of brain.
Intracranial hemorrhage.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 25/5

(a) Date of injury 2-4-48 at about 12.30 p. M.
(b) Where did injury occur? in front-5626 Pennington Ave. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian-struck by auto.
23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 2-5-48

VS 181

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. 559962

559962

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24-4
(c) Hospital or institution: West Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 William St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John T. Higdon

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-4390

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/6/1909

8. AGE: Years	Months	Days	If less than one day
45	2	1	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation ~~Barmaid~~ Boner

11. Industry or business Heinz's Abattoir

FATHER
12. Name John T. Higdon
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Alice T. Smith
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Elizabeth Margaret Higdon
(b) Address 1704 William St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Wed. Feb 11 1948 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto Md.

18 (a) Funeral director A. Howard Evans
(b) Address 1400 E. Monument St.

19 (a) Feb 1948 (Date rec'd by registrar) (b) Livingston Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7 1948 at 3:29 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6 1948 to 2/7 1948 and that I last saw him alive on 2/6 1948

Immediate cause of death Cardiac failure — Duration

Due to Metastatic neoplasm of liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Gordon Brill M. D.

Address West Balto. Gen Hosp Date signed 2/7/48

VS 150

X

G59963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G59963

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 955 Rosedale St.
(c) Hospital or institution: 16-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 955 Rosedale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Emma Jane Hose

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
***	***	Female	White	Widowed

6 (b) Name of husband or wife: Ira D. Hose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 19, 72

8. AGE: Years	Months	Days	If less than one day
76	0	20	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name E. Pierce
13. Birthplace Maryland

MOTHER
14. Maiden Name Louise Lee
15. Birthplace Maryland

16 (a) Informant Mr. Earle Hose
(b) Address 955 Rosedale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director George W. Little
(b) Address 3700 Edmondson Ave.

FEB 9 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8 19 48 at 5:35 M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 24 1948 to Feb 8 1948 and that I last saw her alive on Feb 7 1948.

Immediate cause of death: Gastric Hemorrhage — Duration 2 days
Due to: Hepatic ulcer
Due to:
Other Conditions: Toxic Pneumonia — 5 days

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: ✓
of autopsy: none

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ (Specify type of place) While at work? ✓
(e) Means of injury ✓

23. Signature: John A. Pierce
Address 1219 Poplar Grove St. Date signed 2/9/48

VS 150

117a

G59964

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93E

Registered No. G59964

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1513- N. Bethel St.
(c) Hospital or institution: 8-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1513- Bethel Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELEANOR FLOWERS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 8. 1899

8. AGE: Years	Months	Days	If less than one day
48	12,	29	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Housework.

11. Industry or business

FATHER
12. Name Peter Tkapaskin
13. Birthplace Russia

MOTHER
14. Maiden Name Barbara R Most
15. Birthplace Md

16 (a) Informant Mrs J. Sims
(b) Address Bells and Ft. Ave

17 (a) Burial (b) Date thereof Feb 9 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or Crematory Fork M E. Cem
Location Fork Md

18 (a) Funeral director C E. Arthurs
(b) Address Fork Md

19 (a) Filed Feb 9 1948 (b) Thurlington Williams M.D.
(Date received by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6, 1948, at 12:15 P.M.

21. I certify that I took charge of the remains described above, held an insp.& inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Acute Pulmonary edema.
due to congestive heart failure

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Dr. Wm. G. Murfree per [signature] M.D.
Medical Examiner
Date signed 2-6-48

059965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 059965

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 614 W. Fairmount Ave
(c) Hospital or institution: 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 614 W. Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarinda Cornish

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1857

8. AGE: Years	Months	Days	If less than one day
90	1	9	hr. min.

9. Birthplace Indiana (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER — 12. Name	James Porter
FATHER — 13. Birthplace	Indiana
MOTHER — 14. Maiden Name	?
MOTHER — 15. Birthplace	?

16 (a) Informant Howard A. Cornish
(b) Address 614 W. Fairmount Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 11, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore, Md
18 (a) Funeral director Charles R. Low
(b) Address 882 Madison Ave.
19 (a) FEB 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6/48 19 ; at 2 P M
21. I certify that death occurred on the date above stated; that attended deceased from 1/30/48 19 to 2/6/48 19 ; and that I last saw h[illegible] alive on 2/6/48 19

Immediate cause of death	Duration
Myocarditis	Unknown
Due to	
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Walter L. Lemon M.D.
Address [illegible] Date signed 2/7/48

VS 150

G59966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G59966

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 340 – 23½ St.
(c) Hospital or institution: 12-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Same
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 340 – 23½ St. E
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Welford Smith

3 (b) If veteran, name war
(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Divorced

6 (b) Name of husband or wife Lena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-14-05

8. AGE: Years	Months	Days	If less than one day
42	11	9	20 hr. min.

9. Birthplace Gloster Co., Va.
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Geo. Smith
13. Birthplace Va

MOTHER
14. Maiden Name Elizabeth Lewis
15. Birthplace Va.

16 (a) Informant Thos. R. Smith
(b) Address 1910 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Charles R. Law
(b) Address 602 Madison Ave.

19 (a) (Date rec'd by registrar) (b) Evelington Williams Registrar

FEB 9 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 1948, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1948 to Feb 4 1948
and that I last saw h— alive on Feb 4 1948.

Immediate cause of death	Duration
Lobar Pneumonia	4 Days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos R. Johnson M.D.
Address 2329 Guilford Ave Date signed Feb 6 1948.

X

G59967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

309

Registered No. G59967

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: WOMAN'S HOSPITAL 27-11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 16 WHITEFIELD RD. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Mary Given

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 18 1875

8. AGE: Years 72 | Months 4 | Days 20 | If less than one day hr. min.

9. Birthplace Columbia Pa. (Town, county, and state)

10. Usual Occupation Governess

11. Industry or business

FATHER
12. Name Jefferson Given
13. Birthplace Pa.

MOTHER
14. Maiden Name Margaret Given
15. Birthplace

16 (a) Informant Jere H. Bair
(b) Address 533 Penn St Reading Pa.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 9 1948 (month) (day) (year)
(c) Cemetery or crematory Westminster
Location Montgomery Co Pa.

18 (a) Funeral director Henry N. Jenkins (Jones)
(b) Address McCulloh & Orchard Sts

19 (a) FEB 9 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1948, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary Tuberculosis
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature [illegible] M.D.
Medical Examiner.
Date signed Feb 9 1948

59968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 59968

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2452 McCulloh St.
(c) Hospital or institution: 13-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2452 McCulloh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anne Elizabeth Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No. #

4 Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Thorney La.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25, 1857

8. AGE: Years 90 91 | Months 7 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Mary Milligan
15. Birthplace Va

16 (a) Informant Mrs. Anne B. Burns
(b) Address 2332 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave

19 (a) FEB 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6 1948, at 10 p M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5-1948 to 2-6-1948, and that I last saw her alive on 2-5-1948.

Immediate cause of death	Duration
Chronic Cardio Vascular Renal disease —	1 year
Due to Stroke	3 days
Senility	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. A. Jackson M. D.
Address 600 N. Fulton Ave Date signed 2/9/48

VS 150

659963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 659969

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Rural - Towson 4 (If outside city or town limits, write RURAL and give town)
(d) Street No. Esti-lane (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mildred Lavine Canapp

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Earl F. Canapp
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1918

8. AGE: Years	Months	Days	If less than one day
30	0	4	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Clarence Ford
13. Birthplace Md.

MOTHER
14. Maiden Name Edna Shamblin
15. Birthplace Md.

16 (a) Informant Earl F. Canapp
(b) Address Baguenville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 10, 1948 (month) (day) (year)
(c) Cemetery or crematory Woodland Memorial
Location Parkville, Balto. Co., Md.

18 (a) Funeral director John Bruns Sons
(b) Address Towson, Md.

19 (a) FEB 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 1948, at 6 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 27 Jan. 1948 to 6 Feb. 1948 and that I last saw her alive on 6 Feb. 1948.

Immediate cause of death Pneumonia, staphylococcal (Both lungs Ulcer, T.B. Lung)

Duration

Due to

Due to

Other Conditions Bronchiectasis Bronchial Asthma
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: {Hysterectomy Nutrition to lung of person

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Richard Bowen M. D.
Address Union Memorial Hosp. Date signed 2/9/48

VS 180

659970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 659970

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3340 - Calvert Sts.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. York + Belfast Rds.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel Marie Lippy

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Herbert C. Lippy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1913

8. AGE: Years	Months	Days	If less than one day
34	8	22	hr. min.

9. Birthplace Towson, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Stanley M. Galloway
13. Birthplace Maryland

MOTHER
14. Maiden Name Mabel Parks
15. Birthplace Maryland

16 (a) Informant Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 11, 1948 (month) (day) (year)
(c) Cemetery or crematory Maryland Memorial
Location Parkville, Balto. Co., Md.

18 (a) Funeral director John Burns' Sons
(b) Address Towson, Md.

19 (a) FEB 9 = 1948 (Date rec'd by registrar) (b) Washington Williamson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 Feb. 1948, at 11 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5 Feb 1948 to 7 Feb 1948, and that I last saw her alive on 7 Feb 1948

Immediate cause of death Cerebral Embolus

Due to Post-operative

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2/6/48

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stanley M. Galloway, Jr. M.D.
Address 3943 St. Paul St. Date signed 2/9/48

VS 150

C59971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C59971

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp. 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 134 Wilcox St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] (Albert Davis) Frederick A Davis

3 (b) If veteran, name war —

3 (c) Social Security Account No. 211-07-7059

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife Lillian Madeline
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12 1892

8. AGE: Years	Months	Days	If less than one day
55 [redacted]	7	24	— hr. — min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Carpenter
11. Industry or business —

FATHER
12. Name John Davis
13. Birthplace Bowles Heights Va.

MOTHER
14. Maiden Name Mary Beall Griffith
15. Birthplace Bowles Heights Va.

16 (a) Informant wife
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9, 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location 4300 Old Frederick Rd.

18 (a) Funeral director Edward W. Castellini & Sons
(b) Address 924 E. Eager St.

19 FEB 9 - 1948 (Date rec'd by Registrar) (b) [illegible] Hunting for Williamsburg, Md.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1948, at 10:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/30 1948 to 2/6 1948, and that I last saw him alive on 2/6 1948

Immediate cause of death	Duration
Cardiac Failure	
Due to Coronary Thrombosis	2 wks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Vincent A Battaglia M. D.
Address St. Joseph's Hosp. Date signed 2/9/48

X

G59972

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

Registered No. G59972

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3021 THRASHER CT.
(c) Hospital or institution: 25-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (FAIRAH)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3021 THRASHER CT.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Robert Smith, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/19/47

8. AGE: Years	Months	Days	If less than one day
	2		hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name Elizabeth Smith
15. Birthplace Balto

16 (a) Informant Arthur Fogle
(b) Address 3021 Thrasher Ct Fairfield

17 (a) Burial (b) Date thereof 2-9-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) FEB 9 - 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7 1948, at M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emily Rogers M.D.
Medical Examiner.
Date signed 2-9-48

VS 151

C59973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered C59973

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2433 Foster Ave.
(c) Hospital or institution: — — none — — — 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2433 Foster Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country — — — —

3 (a) **FULL NAME** Rebecca Jane Rexroth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Daniel
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1877

8. AGE: Years	Months	Days	If less than one day
70	3	17	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business —

FATHER
12. Name John Frey
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary ?
15 Birthplace Pa.

16 (a) Informant Fern Harris
(b) Address 2433 Foster Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-12-48 (month) (day) (year)
(c) Cemetery or crematory Dunlo Cem.
Location Dunlo, Pa.

18 (a) Funeral director Lilley & Zeiler Inc.
(b) Address 403 S. Wolfe St.

19 (a) FEB 9 - 1948 (Date rec'd by registrar) (b) Huntington Hill Registrar, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1948, at 12:40 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from July 17 1943 to Feb 8 1948 and that I last saw h[illegible] alive on Feb 8 1948.

Immediate cause of death: General Arterio Sclerosis — Duration 5 yrs
Due to: Chronic Myocarditis — Duration 5 yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton F. Solomon M. D.
Address 129 S. Bway Date signed 2/9/48

C59974

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

Registered No. C59974

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 17-3
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 724 Pierce Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roy Clarke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1946.

8. AGE: Years	Months	Days	If less than one day
1	8 17	8	hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Vernon Clarke.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Lena Whitaker.
15. Birthplace N.C.

16 (a) Informant Vernon Clarke
(b) Address 724 Pierce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9, 1948. (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Mrs Katie R. William
(b) Address 322 N. Schroeder St

19 (a) FEB 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5, 1948, at 8:50 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D. Medical Examiner.
Date signed 2-6-48

VS 131

G59975

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G59975 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3 S.Penn Street.
(c) Hospital or institution: 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3 S.Penn St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN KEEVE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Sadonia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 23, 1897

8. AGE: Years	Months	Days	If less than one day
50	5	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business

FATHER
12. Name Robert Keve
13. Birthplace Heathsville Va.

MOTHER
14. Maiden Name Rachel White
15. Birthplace Eastern Shore Md.

16 (a) Informant Robert Keve
(b) Address 3 Penn St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) FEB 9 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4, 1948, at 2.30 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl C. Rogers M.D.
Medical Examiner

Date signed 2-5-48

059976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 059976

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 819 Warren Street.
(If no street address, give descriptive location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EARL EADS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife Eva Eads

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/31/1901

8. AGE: Years	Months	Days	If less than one day
47 48	-	15	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business Trucking

FATHER
12. Name Samuel Eads
13. Birthplace Md

MOTHER
14. Maiden Name Edna ?
15. Birthplace Md

16 (a) Informant Eva Eads
(b) Address 819 Warren St

17 (a) Burial (b) Date thereof 2/9/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Isaiah L. Brown Son
(b) Address 108 W Monument St

19 (a) FEB 9 - 1948 (b) Huntington Ave Registered
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1948, at 11.20 P M

21. I certify that I took charge of the remains described above, held an insp.& inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Diabetic coma

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Dr. Wm. C. Helfrich M.D.
per
Medical Examiner.
Date signed 2-6-48

VS 131

G59977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 63B

Registered No. G59977

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2724 N Charles St.
(c) Hospital or institution: Doctors Hospital 27-U
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5722 Bertram Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME THERESA BENEDICT

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife JOHN BENEDICT
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1860

8. AGE: Years	Months	Days	If less than one day: hr.	min.
41	11	13	1906	

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Roble Boheme
13. Birthplace —

MOTHER
14. Maiden Name Pauline
15. Birthplace Boheme

16 (a) Informant John Benedict
(b) Address 5922 Bertram Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-12-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Jenkins Brothers
(b) Address 900 E Chestnut

19 (Date rec'd by registrar) FEB 9 1948 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 Feb 1948, at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 24 JAN 1948, to 8 FEB 1948, and that I last saw her alive on 8 FEB 1948.

	Duration
Immediate cause of death Myocardial Failure	2 hrs.
Due to Hypertensive Cardio-Vascular Disease	5 yrs
Due to Thyrotoxicosis	6 yrs +
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Howard M Winkler M.D.
Address 2724 N. Charles

Signed 9 Feb 48

VS 150

G59978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G59978 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3110 Pelham ave
(c) Hospital or institution: 26-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3110 Pelham ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eldred E. Whitaker

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-05-5585

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or~~ divorced.

6 (b) Name of husband or wife Marie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 2-1898

8. AGE: Years 49 | Months 3 | Days 16 | If less than one day hr. min.

9. Birthplace Berlin Md (Town, county, and state)

10. Usual Occupation Guard Service

11. Industry or business British Airways

FATHER
12. Name Jonathan Whitaker
13. Birthplace Berlin Md

MOTHER
14. Maiden Name Eva Clark
15. Birthplace Berlin Md

16 (a) Informant Mrs Marie Whitaker
(b) Address 3110 Pelham ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 10-48 (month) (day) (year)
(c) Cemetery or crematory Bgeto Cem
Location Baltimore

18 (a) Funeral director Jos J Hewlett Son
(b) Address 3001 Kentucky ave

19 (a) [illegible] (b) [illegible] (Signature of Registrar) Taylor Williams, Registrar

FEB 10 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1948, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 1948 to Feb 7 1948, and that I last saw him alive on Feb 7 1948

Immediate cause of death: Acute Coronary occlusion — Duration

Due to:

Due to:

Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter A Anderson M. D.

Address 306 E Chase St Date signed Feb 9-48

X

G59979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

G59979 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1224 Mulberry St.
(c) Hospital or institution: 24-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dasie Shaffer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edward E. Shaffer | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): 6/30/1878

8. AGE: Years: 69 | Months: 7 | Days: 6 | If less than one day: hr. min.

9. Birthplace: Baltimore. (Town, county, and state)

10. Usual Occupation: Head of Fife

11. Industry or business

FATHER
12. Name: Samuel Fox
13. Birthplace: Not Known

MOTHER
14. Maiden Name: Not Known
15. Birthplace

16 (a) Informant: Mrs E. E. Shaffer
(b) Address: 1224 Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/48 (month) (day) (year)
(c) Cemetery or crematory: Glen Haven
Location: Ritchie Highway

18 (a) Funeral director: J. J. Dehoney & Sons
(b) Address: 1818 Light St.

19 (a) FEB 9 1948 (Date rec'd by registrar) (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1948, to Feb 6 1948, and that I last saw h[illegible] alive on Feb 6 1948.

Immediate cause of death	Duration
Chronic Endocarditis	1 yr
Due to — Gangrene of both feet	4 mos
Due to — Chronic Cholangitis	6 mos
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which place) While at work?
(e) Means of injury

23. Signature J. Mallet Williams M. D.

Address 1279 William St Date signed 2/10/48

6

X

G59980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G59980 Registered No. 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1707 Bell St.
(c) Hospital or institution: 24.4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 Bell St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Bessie E. Dregant

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-7679

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widow

6 (b) Name of husband or wife Francis Dregant
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/10/75

8. AGE: Years	Months	Days	If less than one day hr.	min.
72	8	27	16	

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired Nat Engraver
11. Industry or business * Banking Co.

FATHER
12. Name John Brandan
13. Birthplace Ireland

MOTHER
14. Maiden Name Julia Keenan
15. Birthplace Ireland

16 (a) Informant Mr John Markell
(b) Address 1707 Bell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/48 (month) (day) (year)
(c) Cemetery or crematory Catherine.
Location Old Frederick Road

18 (a) Funeral director J. J. Fahey & Sons
(b) Address 1617 Light St.

19 (a) (b)
(Date rec'd by registrar) Registrar

FEB 9 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6 1948 at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1948 to Feb 6 1948 and that I last saw h[illegible] alive on Feb 6 1948

Immediate cause of death Exhaustion — Duration 2 days
Due to
Due to Cerebral Hemorrhage — 22 days
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: No

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. E. Campbell M. D.
Address 1644 Hanover Date signed 2/8/48

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59981 GD. 115664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13

G59981 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 24-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 2
(e) Length of stay in Baltimore (yrs., mos., or days) 58 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1533 Light ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James S. Shirey

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-12-1806

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Anna Bovy.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7 - 1878

8. AGE: Years	Months	Days	If less than one day
69	6	0	hr. min.

9. Birthplace VA. (Town, county, and state)
10. Usual Occupation Butter Maker.
11. Industry or business

FATHER
12. Name ? Wm. D. Shirey.
13. Birthplace ? Va

MOTHER
14. Maiden Name Kelly Ann Good
15. Birthplace ? Va

16 (a) Informant Records B lto. City Hospitals
(b) Address 4940 Eastern Ave. 2/10/48

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway

18 (a) Funeral director Baltimore Sales
(b) Address 120 Light

FEB 9 - 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 7- 1948, at 1.00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12- 4 - 1948 to 2 - 7- 1948, and that I last saw h im alive on 2 - 7- 1948.

	Duration
Immediate cause of death Transverse myelitis	6 mos.
Due to Pott's disease	6 mo.
Due to Tuberculosis	unkn.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julius Block, J.
Address B. C. H. Date signed 2/7/48 M. D.

VS 150

G59982

BC - 48-02813

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

G59982

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Balt Gen Hosp 24-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 12 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1426 Battery Ave
(If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Gerber

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/7/48

8. AGE: Years | Months | Days | If less than one day 12 hr. 15 min.

9. Birthplace Balt. Md.
(Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER
12. Name Phillip Anthony Gerber
13. Birthplace Balt. Md.

MOTHER
14. Maiden Name Mary Agnes Brogan
15. Birthplace Hartford Co. Md.

16 (a) Informant Mrs Phil Gerber
(b) Address 1426 Battery Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/48 (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location Ritchie Highway

18 (a) Funeral director J. J. Kelly Son
(b) Address 1218 Light St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8 1948, at 4:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7 1948 to Feb. 8 1948, and that I last saw h[illegible] alive on Feb 8 1948

Immediate cause of death Atelectasis
Cyanosis
resp. failure.
Due to Prematurity

Due to —

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: —

of autopsy: none

Duration 12.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Ballard

Address 207 Fortune Date signed 2-8-48 M. D.

VS 150

X

G59983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G59983

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24 W Chase St
(c) Hospital or institution: 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 24 W Chase St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John George Nota

3 (b) If veteran, name war
3 (c) Social Security Account No. 212-07-8754

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna Nota
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1874

8. AGE: Years	Months	Days	If less than one day
73 74	3 10	28	hr. min.

9. Birthplace Hungary (Town, county, and state)
10. Usual Occupation Barber
11. Industry or business

FATHER	12. Name Adam Nota
	13. Birthplace Hungary
MOTHER	14. Maiden Name Liddenruch
	15. Birthplace Hungary

16 (a) Informant Mrs Anna Nota
(b) Address 24 W. Chase St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/48 (month) (day) (year)
(c) Cemetery or crematory Mountain
Location Baltimore Md
18 (a) Funeral director William Cook Jr.
(b) Address 1217 E Pratt St
19 (a) FEB 9 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 1948, at 8 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1948 to Feb 7 1948 and that I last saw h[illegible] alive on Feb 7 1948.

Immediate cause of death	Duration
Acute Cardiac Dilatation	2 days
Due to Cardio Vascular disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Glassman M. D.
Address 753 W. Fayette Date signed Feb 9 1948

VS 150

X

59984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 59984

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 543 N. Washington St.
(c) Hospital or institution: 7-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 543 N. Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME May Williamson

3 (b) If veteran, name war --

3 (c) Social Security Account No. 216-09-5033

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Wm. Williamson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1873

8. AGE: Years	Months	Days	If less than one day
74	5	7	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Bookkeeper
11. Industry or business Holmes & Sons

FATHER
12. Name William Holmes
13. Birthplace England

MOTHER
14. Maiden Name Mary C. Forney
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Lillian Brewer
(b) Address 640 N. Chester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 12/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Balto. Md.

18 (a) Funeral director Phillips Herring Sons
(b) Address 2024 Orleans St.

19 (a) Feb 9 1948 (Date rec'd by registrar) (b) Lington Williams MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 1948 at 1:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to Feb 9 1948 and that I last saw her alive on Feb 9 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Hypertensive Cardio-Vascular Disease	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sidney Shapiro MD
Address 244 N. Hilton St Date signed 2-9-48

VS 150

X

G59985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. G59985

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert Sts
(c) Hospital or institution: Union Memorial Hospital 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 E 32nd St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Bertha M. Matthews

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, (widowed), or divorced.
F	W	

6 (b) Name of husband or wife WILLIAM A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1879

8. AGE: Years	Months	Days	If less than one day
68	10	26 18	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business --

FATHER
12. Name John T. Lee
13. Birthplace Md Baltimore.

MOTHER
14. Maiden Name Mary Roadley
15. Birthplace Md. Baltimore.

16 (a) Informant W. A. Matthews
(b) Address 1864 E. 32nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/48 (month) (day) (year)
(c) Cemetery or ~~cemetery~~ Lorraine
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address Baltimore, Md.

19 (Date received by registrar) Feb 9 - 1948 (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 1948 at 3 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1948 to Feb 8 1948, and that I last saw h~~er~~ alive on Feb 8 1948

Immediate cause of death ~~Bronchopneumonia~~ Bronchopneumonia — Duration 1 wk.

Due to ~~Acute myelogenous~~ Leukemia

Due to Acute myelogenous Leukemia — 2 mos

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Results of autopsy: Myelogenous infiltration of bone marrow

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. W. Alford
Address Union Mem. Hosp. Date signed 2-8-48 M. D.

VS 150

G59986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G59986

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27-15
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5719 Ridgedale Rd; City (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. ~~Frances~~ E Mylis (Mary E.)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-18-65

8. AGE: Years	Months	Days	If less than one day
82	10	9	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name George Funk
13. Birthplace Maryland

MOTHER
14. Maiden Name Rose Freeland
15. Birthplace Maryland

16 (a) Informant Mrs. Alma Dalaker
(b) Address 5719 Ridgedale Rd City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md.

18 (a) Funeral director H. H. Ulmer and Son
(b) Address 805 N. Calvert Street.

19 (a) FEB 9 - 1948 (Date rec'd by registrar) (b) Huntington for William

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-8 1948 at 4 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10 1948 to 2-8 1948 and that I last saw her alive on 2-7 1948

Immediate cause of death	Duration
Congestive heart failure	17 days
Pulmonary embolus	
Due to Aortic Stenosis	
Phlebothrombosis of	3 days
Due to left leg	
Fractured L femur	

Other Conditions Arteriosclerosis; Diabetes Mellitus; Fracture L. fem. Rep.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary embolus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27/15
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Jan 20 at M
(c) Where did injury occur? Baltimore (City or town) Md (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury fell down stairs

23. Signature A. W. Alford

Address Union Memorial Hosp Date signed 2-8-48 M. D.

Howard J. Huntington, M.D.

VS 150

659987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

659987 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 9-9
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 42 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1834 N. Caroline St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony S. Parr (Anthony S.Parr)

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex M | **5. Color or race** W | **6 (a) Single, married, widowed, or divorced.** married

6 (b) Name of husband or wife Mrs Clara Parr
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1879

8. AGE: Years 69 | Months 2 | Days 29 | If less than one day ########## min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Police officer

FATHER 12. Name John M. Parr
13. Birthplace Germany

MOTHER 14. Maiden Name Catherine Shelby
15. Birthplace Germany

16 (a) Informant Mrs. Parr (Mrs. Clara Estelle Parr)
(b) Address 1834 N.Caroline Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road, Balto: Md.

18 (a) Funeral director George J.Ruth, Inc.
(b) Address 1735 Harford Avenue

19 FEB 9 - 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7 1948, at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17-1947 to 2-7-1948 and that I last saw h[illegible] alive on 2-7-1948.

Immediate cause of death Pulmonary Embolism — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation (1) 12-22-47 (2) 1-30-48

Major findings of operation: (1) Adenomyoma of prostate & (2) Spontaneous Cecostomy

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank D. Brady M. D.
Address Md. Gen. Hosp. Date signed 2-7-48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

59988 / 95B

Registered 59988

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. St. Vincent Convent, Front St. 132 N Front (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sister Mary Rosabia OSF

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12/24/08

8. AGE: Years	Months	Days	If less than one day
39	1	14	hr. min.

9. Birthplace Delaware (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business

FATHER
12. Name Michael Solomon
13. Birthplace

MOTHER
14. Maiden Name Philomena
15. Birthplace

16 (a) Informant Sr. M. Laetitia OSF
(b) Address St Vincent's Convent.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-10-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Wilmington, Del

18 (a) Funeral director Leonard J. Lynch
(b) Address 1505 Lancaster Pike

19 (a) FEB 9 1948 (Date rec'd by registrar) (b) Certificate filed at Wilmington, Del.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-7 1948, at 9 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-4 1948 to 2-7 1948, and that I last saw her alive on 2-7 1948

Immediate cause of death	Duration
Rheumatic heart disease with congestive failure	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E May M. D.
Address 1400 N. Caroline St Date signed 2-7-48

V S 150

X

G59989 BC-G 82023

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH V157E

G59989 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2912 Liberty Pkwy (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Catherine Dodson

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 26, 1947

8. AGE: Years	Months	Days	If less than one day
	7	11	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Leonard E Dodson
13. Birthplace Idaho

MOTHER
14. Maiden Name Irene Ludwig
15. Birthplace Baltimore Md

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 10, 1948 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Roland L. Fisher
(b) Address 2112 Dundalk Ave.

FEB 9 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-7 1948, at 9:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 9 1948 to Feb 7 1948, and that I last saw h[illegible] alive on Feb 7 1948.

Immediate cause of death: Respiratory failure — Duration 9 hrs
Due to: Congenital heart disease — 9 mos 11 days
Due to:
Other Conditions: Pneumonia — 2 days
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Katherine Sprunt, M. D.
Address Union Memorial Hosp Date signed 2-7-48

VS 150

G59990

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 163H

G59990 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A
(c) Hospital or institution West Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3211 Carlisle Ave (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Frances Derwart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife -----

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 30, 1899

8. AGE: Years	Months	Days	If less than one day
48	9	6	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER 12. Name August Derwart
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Annie A. Schott
15. Birthplace Baltimore, Md.

16 (a) Informant Herbert Derwart
(b) Address 114 Beaumont ave. Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location 4th & Frederick Road

18 (a) Funeral director Chas. J. Evans & Son, Inc.
(b) Address 118 N. Mt. Royal Ave

19 (a) Received FEB 9 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/8 1948, at 8:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to last death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to illuminating gas - CO

Due to

Other Conditions Despondency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2/6/48 at about 4:00 P.M.
(b) Where did injury occur? 3211 Carlisle Ave
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Gas inhalation - Asphyxiation and burns

23. Signature Huntington Williams M.D. Medical Examiner.
Date signed 2/9/48

VS 151

G59991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G59991 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2432 East Ashland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 65 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2432 Ashland Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN KAISER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	MARRIED

6 (b) Name of husband or wife ELIZABETH KAISER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 1 - 1875

8. AGE: Years	Months	Days	If less than one day
72	9	6	hr. min.

9. Birthplace GERMANY (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name JOSEPH KAISER
13. Birthplace GERMANY

MOTHER
14. Maiden Name JOSEPHINE WALDHAUSER
15. Birthplace GERMANY

16 (a) Informant ELIZABETH KAISER
(b) Address 2432 E. ASHLAND AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB 11-48 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director CHAS. F. EVANS & SON
(b) Address 118 W. MT ROYAL AVE

19 (a) 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/7/48 19 , at 3:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to DHS death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions Carcinoma Rectum

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Evans M.D. Medical Examiner.
Date signed 2/8/48

93

G59992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G59992 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: CATON & MILLERS AVE
(c) Hospital or institution: ST. AGNES HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days): 5 days
(e) Length of stay in Baltimore (yrs., mos., or days): —

2. USUAL RESIDENCE OF DECEASED:
(a) State: MD. (b) County: —
(c) City or town: BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No.: ST. MARY'S INDUSTRIAL School — CATON & MILLERS (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country:

3 (a) FULL NAME: JOHN J. GALLAGHER

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: Kitty GALLAGHER

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3/21/1886

8. AGE: Years: 61 | Months: 10 | Days: 17 | If less than one day: hr. min.

9. Birthplace: — BALTIMORE (Town, county, and state)

10. Usual Occupation: Watchman

11. Industry or business: St. Mary's Ind. School

FATHER
12. Name: THOMAS GALLAGHER
13. Birthplace: IRELAND

MOTHER
14. Maiden Name: MARY CONSADINE
15. Birthplace: MD.

16 (a) Informant: MRS. M. T. ZINN
(b) Address: 827 Mt Holly Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb 10 48 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location: OLD FREDERICK RD.

18 (a) Funeral director: Chas. F. Evans & Son
(b) Address: 118 W Mt. Royal Ave

19 (a) 2-8-48 (Date rec'd by registrar) (b) Arthur Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/8/1948, at 2:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/3/1948 to 2/8/1948, and that I last saw him alive on 2/2/1948.

	Duration
Immediate cause of death: INTESSINAL OBSTRUCTION	
Due to: CARCINOMA OF RECTUM	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation: 2-6-48

Major findings of operation: CLOSED LOOP OBSTRUCTION - CARCINOMA OF RECTUM

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: John F. Linn M. D.

Address: ST. AGNES HOS. Date signed: 2/8/48

X

G59993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G59993
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2603 York Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Grayson, Sr.
3 (b) If veteran, name war: NO
3 (c) Social Security Account No.
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Janet
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 10 1887
8. AGE: Years 60 | Months 11 | Days 29 | If less than one day hr. min.
9. Birthplace Lonaconing, Md.
(Town, county, and state)
10. Usual Occupation airplane mech.
11. Industry or business Martin & Co.

FATHER
12. Name ? Grayson
13. Birthplace ?

MOTHER
14. Maiden Name Mary ?
15. Birthplace ?

16 (a) Informant Mrs. John W. Grayson, Jr.
(b) Address 2603 York Way, Dundalk
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/12/48 (month) (day) (year)
(c) Cemetery or crematory
Location Lonaconing, Md.
18 (a) Funeral director M. Eichorn
(b) Address Lonaconing Md.
19 (a) (b) Registrar
(Date rec'd by registrar) FEB 9 1948
VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 February 1948, at 10:00 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 2 Feb 1948 to 8 Feb 1948, and that I last saw him alive on 7 Feb 1948.

Immediate cause of death: Surgical shock — Duration —
Due to: Total gastrectomy
Due to:
Other Conditions: Gastric ulcer — 5-4 yrs
(Include pregnancy within 3 months of death)
Date of operation 9 Feb 48
Major findings of operation: Ulcer (type undetermined as yet) on lesser curv.
of autopsy: Hotly stitching

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 9 Feb. '48
(c) Where did injury occur? Sinai Hospital M
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hosp. (Sinai) While at work? No
(Specify type of place)
(e) Means of injury Died on operating table (90E)
23. Signature M Taylor M. D.
Address Sinai Hospital Date signed 9 Feb 48
approved: Howard J. Taussig, M.D.

To be reviewed by M.E. 2/12/48 X

Std G59994

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G59994 Registered No. 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 719 N. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Beulah Elizabeth ~~Kearns~~ or Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lt. Col. B. Johnson Retired

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1907 June 20, 1910

8. AGE: Years ~~40 but~~ 37 | Months 7 | Days ~~10~~ 18 | If less than one day hr. min.

9. Birthplace Dalton, Georgia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Clarence Martin
13. Birthplace Georgia

MOTHER
14. Maiden Name Florence Martin
15. Birthplace Georgia

16 (a) Informant Clarence L. Martin
(b) Address 1041 Hillen Street

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb. 9, 1948 (month) (day) (year)
(c) Cemetery or crematory Dublin Cem.
Location Dublin, Georgia

18 (a) Funeral director William Cook, Icn
(b) Address 1217 St. Paul Street

FEB 9 1948 Funeral Director, Baltimore, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1, 1948, at 4.40 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar pneumonia

Due to

Other Conditions Fatty Degeneration of Liver

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Rogers M.D. Medical Examiner

Date signed 2-2-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G59995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G59995 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1702 Park Ave.
(c) Hospital or institution: 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sallie-Thornton-Ward.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	W.

6 (b) Name of husband or wife George W. Ward
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 3-1875

8. AGE: Years	Months	Days	If less than one day
73	1	4	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Benaiah Thornton
13. Birthplace England

MOTHER 14. Maiden Name Amanda Stirling
15. Birthplace Maryland

16 (a) Informant Mrs Jos. F. Flynn
(b) Address 1702 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-10-1948 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) FEB 9 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7- 1948, at 8:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1947 to 2/7 1948 and that I last saw her alive on Jan 12 1948

Immediate cause of death	Duration
Cerebral hemorrhage	10 min.
Due to hypertension arteriosclerosis C.V.D.	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Franklin E. Fuller M. D.
Address 1101 St Paul Date signed 2/9/48

VS 153

G59996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

X G59996

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days): DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: New York (b) County
(c) City or town: Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. 675 East Fifth Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph KAPLAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1877

8. AGE: Years: 71 Months: Days: If less than one day hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Installment Business

11. Industry or business

FATHER
12. Name: Elie
13. Birthplace: Russia

MOTHER
14. Maiden Name: Not Known
15. Birthplace: Russia

16 (a) Informant: Mrs Gert Goldberg
(b) Address: 741 E 4 St Bklyn NY

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2-11-48 (month) (day) (year)
(c) Cemetery or crematory: Mt Hebron Cem
Location: Brooklyn New York

18 (a) Funeral director: Jack Kevs Inc
(b) Address: 760 Eutaw Place

19 (a) (Date received by Local Registrar) (b) Registrar

VS 561

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/9/48 19 at 3:10 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: John R Davis M.D. Medical Examiner.
Date signed 2/9/48

X

C59997

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1948

Registered No. C59997

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 464 E. Cross Street
(c) Hospital or institution: 24-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 464 E. Cross Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES SANDERSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married-Separated

6 (b) Name of husband or wife Annie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 15, 1890

8. AGE: Years	Months	Days	If less than one day
57	4	24	hr. min.

9. Birthplace Olyphant, Penna.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Pepsi-Cola Co.

FATHER
12. Name John W. Sanderson
13. Birthplace England

MOTHER
14. Maiden Name Mary E. Taylor
15. Birthplace England

16 (a) Informant MRS. GEORGE SACHUK
(b) Address 464 E. CROSS ST.

17 (a) Removal (b) Date thereof Feb. 9, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Prospect Cem.
Location Peckville, Penna.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) FEB 10 1948 (b) Huntingdon Pennsylvania
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 9 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1948 to 2/9 1948
and that I last saw him alive on 2/7 1948.

Immediate cause of death	Duration
(a) Coronary Occlusion	5 min.
Due to (b) Arterial Hypertension	2 Yrs.
Due to (c)	
Other Conditions	2 mths

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O. B. Walsh M. D.
Address 127 Williams Date signed 2/9/48

VS 150

659998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. 659998

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W. Lexington St.
(c) Hospital or institution:
Aged Women's Aged Men's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sandia Charles La Compte

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Beasley LaCompte
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov 28. 1856

8. AGE: Years	Months	Days	If less than one day
91	4 2	9	hr. min.

9. Birthplace Federalsburg Caroline Co (Town, county, and state) Md.
10. Usual Occupation Inmate
11. Industry or business Home for Aged

FATHER
12. Name William Henry Charles
13. Birthplace

MOTHER
14. Maiden Name Charlotte Adams
15. Birthplace

16 (a) Informant L. B. Read Supt
(b) Address 1400 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/48 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Frederick Ave

18 (a) Funeral director Wm Cook Jr
(b) Address 212 S. St Paul St

FEB 10 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7th 1948, at 2:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1948, to Feb 7 1948, and that I last saw her alive on Feb 6 1948.

Immediate cause of death	Duration
Respiratory Failure	
Due to Uremia	
Due to Nephritis, Chronic	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maryland Edward Day M. D.
Address 4-E-33rd St Balto 18 Date signed Feb 9 1948

V S 150

659999

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

659999 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2834 Guilford Ave.
(c) Hospital or institution: none 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2834 Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Jane W. Arthur

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	divorced

6 (b) Name of husband or wife Dr. Harry H. Arthur
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 5, 1869

8. AGE: Years	Months	Days	If less than one day
78	3	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Registered nurse,
11. Industry or business retired

FATHER
12. Name Robert J. Waterworth
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Jane Taylor
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Eula E. Rothange
(b) Address 624 North Bend Road

17 (a) Burial (b) Date thereof 2/10/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~Cremation~~ Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) FEB 10 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1948, at 4:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 August 1946 to 8 Feb 1948, and that I last saw her alive on 8 Feb 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 hours
Due to Hypertensive Cardio-vascular disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Douglas Lockard M. D.
Address 802 Cathedral St. Date signed 9 Feb, 1948

VS 150

X

G60000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G60000 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland 27-14

(b) Street address Greene & Lombard ST

(c) Hospital or institution: Univ. Hosp. Balto. Md.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 417 Hawthorne Rd. (If rural give location)

(e) Citizen of foreign country? none (Yes or No)

If yes, name country

3 (a) **FULL NAME** Wm William Roberts. (William C. Roberts) ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Mabel Junkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1880

8. AGE: Years	Months	Days	If less than one day
67 (68)	--	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation fuel

11. Industry or business

FATHER

12. Name William C. Roberts

13. Birthplace Md.

MOTHER

14. Maiden Name Lida Phillips

15. Birthplace Md.

16 (a) Informant Mrs. Mabel J. Roberts

(b) Address 417 Hawthorne Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/48 (month) (day) (year)

(c) Cemetery or ~~Crematory~~ Greenmount

Location North & Greenmount Aves.

18 (a) Funeral director John O. Mitchell & Sons, Inc.

(b) Address 1900 Eutaw Place

19 (a) FEB 10 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-8 1948, at 4:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-24 1948 to 2-8 1948, and that I last saw him alive on 2-8 1948.

Immediate cause of death Cardiac decompensation

Due to pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Howard E. Hall M. D.

Address Univ. Hosp. Date signed 2-8-48

VS 150

X

G60001

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. G60001

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 26-6
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1421 Bennaccy Way (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Arthur R. Bateman
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of ~~husband~~ or wife Grace Bateman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2. 1894

8. AGE: Years 53 | Months 11 10 | Days 6 | If less than one day hr. min.

9. Birthplace Virginia (Town, county and state)
10. Usual Occupation Mechanic
11. Industry or business Gov't.

FATHER
12. Name Samuel Bateman
13. Birthplace Virginia

MOTHER
14. Maiden Name Emma Bryan
15. Birthplace Virginia

16 (a) Informant Grace Bateman
(b) Address 1421 Bennaccy Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby. 11 1948 (month) (day) (year)
(c) Cemetery or crematory Presbyterian Cem
Location Lynchburg Va

18 (a) Funeral director John D. Mitchell Home
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/8/48 19 , at 1 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/7/48 19 to 2/8/48 19 , and that I last saw h alive on 2/8/48 19 .

Immediate cause of death	Duration
(a) Sclerosis coronary disease	
Due to (b) Coronary occlusion	- 3 months
Due to (c) Myocardial degeneration	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Church Home & Hospital Date signed 2/9/48 M.D.

G60002

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. G60002

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution Mt Sinai Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 914 No Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eva Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Simon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1895

8. AGE: Years 53 | Months | Days | If less than one day: hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Louis
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Aaron Cohen
(b) Address 5725 Narcissus Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-10-48 (month) (day) (year)
(c) Cemetery or crematory Location Hebrew Mt Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 2160 Eutaw Place Huntington Woodlawn, Md

19 (a) FEB 10 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-9- 1948, at 11:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 5 1948 to FEB 9, 1948, and that I last saw h[illegible] alive on Feb 9, 1948.

Immediate cause of death	Duration
Coronary Thrombosis	2 Days
Due to Arteriosclerotic heart disease	5 Years
Due to Hypertension	5 Years
Other Conditions Diabetes mellitus	5 Years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis B. Moses, M.D. M. D.
Address 448 N. Eutaw Ave Date signed 2-9-48

VS 150

937

G60003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

307

G60003 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 22-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 842- Sharp Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Corine NICHOLSON

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	M

6 (b) Name of husband or wife Walker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace Unknown (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Walter Nicholson (H)
(b) Address 842 Sharp St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Balto City

18 (a) Funeral director Isaac L. Brown & Son
(b) Address 101 W Montgomery St

19 FEB 10 1948 (Date rec'd by registrar) (Signature of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1, 1948, at 2.15 P M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Syphilitic aortitis.
Dilatation of heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 2/2/48

VS 151

G60004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 184

Registered No. G60004

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave's
(c) Hospital or institution: St. Agnes Hospital 20-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2655 Lehman Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lester L. Bartlett

3 (b) If veteran, name war: WW II

3 (c) Social Security Account No. 212-03-9574

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alverta M. Bartlett

6 (c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): July 4 th 1913

8. AGE: Years 34 | Months 7 | Days 2 | If less than one day: hr. min.

9. Birthplace: Hagerstown Md.
(Town, county, and state)

10. Usual Occupation: Steel Worker

11. Industry or business: U.S.Steel Co.

FATHER
12. Name: Louis F. Bartlett
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Agnes Jordan
15. Birthplace: Virginia

16 (a) Informant: Mrs. Alverta M. Bartlett
(b) Address: 2655 Lehman Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 10 48 (month) (day) (year)
(c) Cemetery or crematory: New National Cem.
Location: Baltimore Maryland

18 (a) Funeral director: F.B.WIPPERT & SON
(b) Address: 1300 EUTAW PLACE....17

19 (a) FEB 10 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6, 1948, at 11.45 a M

21. I certify that I took charge of the remains described above, held an partial autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wound of brain

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 20/5
(a) Date of injury 2-5-48 at 3 p. M.
(b) Where did injury occur? 2655 Lehman St. Balto.Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature [signature] M.D.
Medical Examiner.
Date signed 2-6-48

VS 181

X

G60005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G60005

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 8-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 13 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1528 N. Broadway (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME ROLEY PITT MOXLEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Mary J. Moxley
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) July 25 1879

8. AGE: Years	Months	Days	If less than one day
68	6	14/5	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Amer. Smelting & Ref. Co.
11. Industry or business Retired 23 yrs.

FATHER
12. Name Benjamin Moxley
13. Birthplace Penna

MOTHER
14. Maiden Name Judith Reynolds
15. Birthplace Virginia

16 (a) Informant Mrs. Mary J. Moxley
(b) Address 1528 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 12. 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Baltimore

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address Baltimore 13 Md.

19 (a) FEB 10 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Feb. 1948 10:07 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. K. Kammerer Jr. M.D. Medical Examiner.
Date signed 9 Feb. 48

G60006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G60006 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3127 Guilford Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Kathryn Childress Patterson

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 6, 1907

8. AGE: Years	Months	Days	If less than one day
40	10	4	hr. min.

9. Birthplace Caldwell Co. Ky. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Wiley Childress
13. Birthplace Ky.

MOTHER
14. Maiden Name Florence Adams
15. Birthplace Ky.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 13 48 (month) (day) (year)
(c) Cemetery or crematory Location Caldwell, Ky.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 (a) FEB 10 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10 1948, at 8:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 6 1948, to Feb. 10 1948, and that I last saw her alive on Feb. 10 1948.

Immediate cause of death Adenocarcinoma of right breast (resected 1942) with metastasis to right axilla, ribs, pleura, skull, liver and lungs — Duration: UNKNOWN

Due to

Due to

Other Conditions Pneumonia, bronchial, right lower lobe, terminal — Duration: 2-3 days
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 2/10/48

G60007

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

181

Registered No. G60007

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 University Pkwy
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 120 W University Pkwy (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2 1888

8. AGE: Years 59 | Months 5 | Days 6 | If less than one day hr. min.

9. Birthplace Oakland Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James C Gittings

13. Birthplace Md

MOTHER 14. Maiden Name Emma List

15. Birthplace Wheeling W. Va.

16 (a) Informant Mr. D List Warner

(b) Address Munsey Bldg

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 10 1948 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Green Mount

Location Balto. Md

18 (a) Funeral director Henry N Jenkins & Son Co

(b) Address McCulloh & Orchard Sts

19 (a) Feb 10 1948 (Date rec'd by registrar) (b) Hunter Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/8 1948, at 12 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions 2nd - 3rd degree burns 95% body

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:

(a) Date of injury 2/8/48 at about 9:30 P.M. 12/1

(b) Where did injury occur? 100 University Pkwy

(c) Did injury occur at home, on farm, industrial place, in public place? Apartment house While at work? No

(d) Means of injury Scalded in bath-tub Following

23. Signature Hunter Williams Coroner & Medical Examiner M.D.

Date signed 2/9/48

G60008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

Registered No. G60008

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Cabot St
(c) Hospital or institution: Union Memorial Hospital 27-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 days
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5647 Gorsuch Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Rosella M. Holland

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Oliver S Holland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 19, 1875

8. AGE: Years	Months	Days	If less than one day
72	2	20	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name James Francis
FATHER 13. Birthplace Balto, Md

MOTHER 14. Maiden Name German
MOTHER 15. Birthplace Md

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 11 1948 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson Md.

18 (a) Funeral director Henry W Jenkins & Sons
(b) Address McCulloh & Orchard Sts

19 FEB 10 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 1948, at 10 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1948 to Feb 8 1948 and that I last saw her alive on Feb 8 1948

Immediate cause of death Coronary occlusion — Duration 1 day
Due to Coronary occlusion
Due to
Other Conditions Diabetes mellitus — 20 yrs.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Coronary occlusion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address [illegible] Date signed

VS 150

HOP 94a 2948

G60009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G60009 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 Calhoun St
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2140 Aiken St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Caulson

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-26-8576

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Margaret B. Coulson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-7-1892

8. AGE: Years 55 56 | Months 8 | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name James A. Coulson
13. Birthplace Maryland

MOTHER 14. Maiden Name Sibilipine Henkelmann
15. Birthplace Maryland

16 (a) Informant Margaret B. Coulson
(b) Address 2140 Aiken St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-11-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director John A. Mason
(b) Address 3000 E. Fort Ave.

19 (c) FEB 10 1948 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 Feb 1948, at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7 Feb 1948 to 7 Feb 1948, and that I last saw him alive on 7 Feb 1948

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Hypertention — Duration

Cardio vascular disease — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cerebral Hemorrhage

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature V. A. Lacace

Address Franklin Square Hospital Date signed 8 Feb 48

VS 180

G60010 Over

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. G60010

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3017 E. Balt. St
(c) Hospital or institution: 1-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State M. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3017 E Balt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wm. F. Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Augusta C. Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 26-187[illegible]

8. AGE: Years: 75 | Months: 8 | Days: 14 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business: B. O. R. R.

FATHER
12. Name: John Williams
13. Birthplace: Maryland

MOTHER
14. Maiden Name: ?
15 Birthplace: ?

16 (a) Informant: Augusta C. Williams
(b) Address: 3017 E. Balt. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-12-1948 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Frederick Rd

18 (a) Funeral director: John O. Moran
(b) Address: 3000 - E. Balt. St. [illegible]

19 (a) FEB 10 1948 (Date received by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9th 1948, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1947, to Feb. 9 1948, and that I last saw h.[illegible] alive on Feb 8 1948

Immediate cause of death	Duration
3 Uremia	
Due to Cardio renal disease	
Due to Prostatic hypertrophy. Endocarditis.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles B. MacMunn M. D.

Address 2911 E Balt St Date signed Feb 9 1948

VS 150

X

(C)50011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. C50011

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 801- Reed Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 801 Reed Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Adams.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1884

8. AGE: Years 63 | Months 3 | Days 7 | If less than one day hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER 12. Name James Adams

13. Birthplace Md.

MOTHER 14. Maiden Name

15. Birthplace Md.

16 (a) Informant Levi Adams

(b) Address 1235 Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Mt. Calvary

18 (a) Funeral director A. Halstead

(b) Address 918 Reed Hill Ave.

19 (a) Feb 10 1948 (Date received by local registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-8-1948, at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-6-1948 to 2-8-1948 and that I last saw him alive on 2-8-1948.

Immediate cause of death: Arteriosclerosis Cardiac Disease — Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address Date signed 2-9-48

VS 150

- 6 -

50012 G.

113980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V. 14

Registered 50012

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
B_lto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Months
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State MDL. (b) County Howard Hundred
(c) City or town Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No. Pasadena Box 111
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Lane

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13 - 1939

8. AGE: Years	Months	Days	If less than one day
8	2	24	hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Victoria Johnson
15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 10 48 (month) (day) (year)
(c) Cemetery or crematory Mongolia
Location

18 (a) Funeral director Wm. A. Jackson
(b) Address 916 Reman Avenue

19 (a) 2 10 1948 (Date rec'd by local Registrar) (b) Huntington Williams M.D. (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 7 - 1948, at 1.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9 - 21 - 1948 to 2 - 7 - 1948, and that I last saw her alive on 2 - 7 - 1948.

Immediate cause of death	Duration
Tuberculous Meningitis	1 wk
Due to	
Due to	
Other Conditions Tuberculosis ?	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Tbc Meningitis. Pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julian P. Griffin M. D.
Address Balto City Hosps Date signed 8 Feb 48

VS 150

X

G60013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G60013

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. 20-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 540 N. Pulaski St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MRS LULA Elizabeth ESCHBACH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Geo. Eshbach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1879

8. AGE: Years	Months	Days	If less than one day
68	8	6	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation –
11. Industry or business –

FATHER
12. Name Joseph Johnson
13. Birthplace Baltimore

MOTHER
14. Maiden Name Matilda Summerfield
15 Birthplace Baltimore

16 (a) Informant Mrs. Frank Spiegel
(b) Address Ridge Rd., Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 10 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1948, at 1 05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7 1948 to Feb. 7, 1948 and that I last saw her alive on Feb 7 1948

Immediate cause of death Pulmonary Edema — Duration

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions Bronchopneumonia Pyelonephrosis + Diabetes.
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allan Y. Wolinsky M. D.
Address Sinai Hosp. Date signed 2-7-48

VS 150

937

G60014

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G60014

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1805 Hope St.
(c) Hospital or institution: 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1805 Hope St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** HOWARD FRANKLIN GREEN

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 214-01-1644

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Florence B. Green

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 3, 1876

8. **AGE:** Years 69 | Months 8 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Hecht's Furniture Co.

11. Industry or business

FATHER
12. Name John D. Green
13. Birthplace Baltimore

MOTHER
14. Maiden Name Scranda Harris
15. Birthplace Md.

16 (a) Informant Mrs. Florence B. Green
(b) Address 1805 Hope St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/48 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 10 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7, 1948, at 11:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1947, to Feb 7 1948, and that I last saw h[illegible] alive on Feb 6 1948.

	Duration
Immediate cause of death: Chronic Myocarditis	
Due to Arteriosclerotic Cardiovascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard B. Wolfe M. D.
Address 133 E. Lanvale St. Date signed 2-9-48.

VS 150

660015

GM. 89808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 660015

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

T-5

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 N. Washington ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Raymond Gurney

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Annie K. Gurney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11 1865

8. AGE: Years	Months	Days	If less than one day
82	4	29	hr. min.

9. Birthplace MD. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Nathan Gurney
13. Birthplace ?

MOTHER
14. Maiden Name Adelina Frantom
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 12/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto. Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 (a) FEB 10 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 9 1948, at 3.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-25-1944, to 2-9-1948, and that I last saw h im alive on 2-9-1948.

Immediate cause of death Heart Failure — Duration 2da
Due to Arteriosclerotic C-V disease — 4yr
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None permitted

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William M. Stanglet M.D.
Address Balto City Hospital Date signed 2/9/48

VS 150

G60016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G60016 Registered No.

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16 y 8 Williams
(c) Hospital or institution: 7-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No 16 y 8 Williams St (If rural give location)
(e) Citizen of foreign country? MILTARY (Yes or No) If yes, name country

3 (a) FULL NAME Louise Risel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Willie | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 8, 1892

8. AGE: Years 55 | Months 5 | Days 29 | If less than one day: hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER — 12. Name Hobert Goodwin

13. Birthplace Va

MOTHER — 14. Maiden Name Mary Brookfield

15. Birthplace Va

16 (a) Informant Mable Charity

(b) Address 16 y 8 Williams St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 10 48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem

Location Balto Co

18 (a) Funeral director Mrs. L. Elliott Daughter

(b) Address 1129 N. Carolina St.

19 (a) FEB 10 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1948 at 1:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 1948 to Feb 7 1948 and that I last saw h alive on Feb 6 1948

Immediate cause of death: Cerebral Hemorrhage — Duration: 19 days

Due to: Hypertension — Duration: Indef

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J Edward Fisher M. D.
Address 1616 E Monument Date signed 2/10/48

G60017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77c

Registered No. G60017

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1533 N. Eden Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN CUNNINGHAM

3 (b) If veteran, name war: World War #2
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 29, 1925
8. AGE: Years 23 | Months - | Days 11 | If less than one day: hr. min.
9. Birthplace Petersburg Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name James Cunningham
13. Birthplace Va.

MOTHER
14. Maiden Name Agnes Cunningham
15. Birthplace Va

16 (a) Informant Geraldine Cunningham
(b) Address 1533 N. Eden St.

17 (a) Removal (b) Date thereof Feb 10/48 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Petersburg Va

18 (a) Funeral director Mrs. Otis Abbott & Dgt.
(b) Address 1297 N. Caroline St.

19 (a) FEB 10 1948 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9, 1948, at 8.15 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute alcoholism.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 2-9-48

G60018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G60018 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2020 Pennsylvania Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Hainey

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Robert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9-1897

8. AGE: Years 50 | Months 4 | Days 27 | If less than one day hr. min.

9. Birthplace md (Town, county, state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Ben Bickson
13. Birthplace md

MOTHER
14. Maiden Name
15. Birthplace md

16 (a) Informant Mary Bickson
(b) Address 2020 Penna Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/48 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location md

18 (a) Funeral director Wm. H. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) FEB 10 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6/48 19 , at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Phil R. Davis M.D. Medical Examiner.
Date signed 2/6/48

VS 151

X

G60019

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G60019
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1512 E. Baltimore St
(c) Hospital or institution: 6-5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 E. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George F. Yates George Yeates

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Jannie Yates
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1861

8. AGE: Years	Months	Days	If less than one day
86	3	4 6	hr. min.

9. Birthplace Delaware
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Joseph O. Yates
(b) Address 1512 E. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 11 48 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Pk.
Location Taylor Ave.

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. Wolfe St.

19 (a) FEB 10 1948 (Date rec'd by registrar) (b) Filed by Worthington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/8 1948, at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C.V. Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 2/9/48

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 050020

050020

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 W. Chesapeake Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) **FULL NAME** Mildred A. Donnell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 22, 1891

8. AGE: Years	Months	Days	If less than one day
57	0	17	— hr. — min.

9. Birthplace N. Palermo, Maine (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business at Home

FATHER
12. Name John S. Ayer
13. Birthplace Maine

MOTHER
14. Maiden Name Carolyn Wharton
15. Birthplace Maine

16 (a) Informant Mrs. P. O. Baker
(b) Address Providence, R. I.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb. 10, 1948 (month) (day) (year)
(c) Cemetery or crematory Ray O. Page Funeral Home
Location 260 Elmwood Ave., Providence, R. I.

18 (a) Funeral director John Burns' Sons
(b) Address Towson, Maryland

19 (a) FEB 10 1948 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Feb. 1948 at 9:45 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D. Medical Examiner.
Date signed 9 Feb. 48

660021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

660021 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3732 Columbus Dr
(c) Hospital or institution: — 15-11
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3732 Columbus Dr
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME John H. Ruppel

3 (b) If veteran, name war —

3 (c) Social Security Account No. 705-09-024

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Mary Annie Louise Ruppel (Nee Kraft)

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 4, 1878

8. AGE: Years 69 | Months 4 | Days 4 | If less than one day — hr. — min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired Carman

11. Industry or business B & O R R

FATHER
12. Name William Ruppel
13. Birthplace Balto Md

MOTHER
14. Maiden Name Jennie (?)
15. Birthplace Balto Md

16 (a) Informant Mrs. Lorraine E. Robbins
(b) Address 3732 Columbus Dr. (niece)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Wed. Feb 11, 1948 (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location Balto Md

18 (a) Funeral director A. Bernard Evans
(b) Address 4202 Charles St Balto 18 Md

19 FEB 10 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1, Feb 8, 1948, at 2:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to Feb 8 1948 and that I last saw h(im) alive on Feb 8 1948

Immediate cause of death — Duration 3 days
CORONARY THROMBOSIS

Due to ARTERIOSCLEROTIC HEART DISEASE — 6 years

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Manuel Levin M. D.
Address 4818 Reisterstown Rd Date signed Feb 9/48

VS 150

X

The G50022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G50022

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1314 Hanover St.
(c) Hospital or institution: 231
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 Hanover St.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Mary L. Caskey

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Thomas J. Caskey
6 (c) If alive, give age 86 years

7. Birth date of deceased (mo., day, yr.) April 2, 1865

8. AGE: Years	Months	Days	If less than one day
82	10	6	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Pletz
13. Birthplace Germany

MOTHER
14. Maiden Name ? ?
15. Birthplace Germany

16 (a) Informant Thomas J. Caskey (Husband)
(b) Address 1314 Hanover St, Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 11 1948 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore Md. - (Western Cemetery)

18 (a) Funeral director A. Howard Evans
(b) Address 4403 S. Charles St Baltimore Md.

19 (a) FEB 10 1948 (Date rec'd by registrar) by Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sun Feb. 8, 1948, at 1:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1, 1947 to Feb. 8, 1948 and that I last saw h[illegible] alive on Feb. 8, 1948.

Immediate cause of death Cerebral Hemorrhage — Duration —
Due to Arterio Sclerosis — —
Heart Disease — —
Due to — — —
Other Conditions Chronic myocarditis — —
& Cystitis Feb. 8 — —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —
23. Signature H. P. Friedman M. D.
Address 1319 Eutaw St. Date signed 2/9/48

VS 150

650023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 650023

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Inwood - 6 west St

(c) Hospital or institution: Univ. Hospital 13-8

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 3655 Oak St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John D Riley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	married

6 (b) Name of husband or wife Cora Riley

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr) Feb 15, 1881

8. AGE: Years	Months	Days	If less than one day
66	11	24	hr. min.

9. Birthplace Md (Town, county and state)

10. Usual Occupation Park Police

11. Industry or business Balto City.

MOTHER / FATHER

12. Name Alexander Riley.

13. Birthplace ?

MOTHER / FATHER

14. Maiden Name Louise French

15. Birthplace Md.

16 (a) Informant Cora Riley

(b) Address 3665 Oak St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 12 1948 (month) (day) (year)

(c) Cemetery or crematory Baltimore.

Location North Ave.

18 (a) Funeral director A Langrall & Donovan

(b) Address 3615-17 Eastern Ave.

19 (a) Feb 10 1948 (Registered by registrar) (b) Lawrington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9/48 19 , at 12:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/8/48 19 to 2/9/48 19 , and that I last saw him alive on 2/9/48 19 .

Immediate cause of death Pulmonary edema

Due to Coronary Occlusion

Due to Arteriosclerosis & Diabetes Mellitus

Other Conditions Rt Inguinal hernia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: SAME

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature D. A. Romano M. D.

Address Univ. Hosp. Date signed 2/7/48

VS 150

X

(S)50024 JL - 87831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. (S)50024

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 26-17
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No address (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laura E. Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife William (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11. 1861

8. AGE: Years	Months	Days	If less than one day
86	3	28	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Wimert
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Fethers
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2- 11 48 (month) (day) (year)
(c) Cemetery or crematory Westminster
Location Westminster, Maryland

18 (a) Funeral director Lorenz Byrne
(b) Address 5005 Park Heights Ave

19 (a) FEB 10 1948 (Date rec'd by registrar) (b) Huntington for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8 1948, at 7:40 Pm M

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1944, to Feb. 8 1948, and that I last saw her alive on Feb. 8 1948.

Immediate cause of death Cardiac failure.
Due to Arteriosclerotic Heart disease
Due to
Other Conditions Uremia & nephrosclerosis.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. T. Bamford M. D.
Address Balt. City Hosp. Date signed 2-9-48

VS 150

937

10025 BC-48-02572 104a Registered No. 10025

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 40 Bloomingdale Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JUNE L. JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/[illegible]/48

8. AGE: Years | Months: 1 | Days | If less than one day: hr. min.

9. Birthplace Baltimore City
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Woodson Johnson
13. Birthplace Marlboro Md

MOTHER
14. Maiden Name Corrine Dorsey
15. Birthplace Baltimore City

16 (a) Informant Woodson Johnson
(b) Address Marlboro, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 11-1948 (month) (day) (year)
(c) Cemetery or crematory Jennings Chapel
Location Marlboro, Md

18 (a) Funeral director Howard S. Mackenzie
(b) Address Upper Marlboro Md

19 (a) FEB 10 1948 (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9, 1948, at 4.50 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Uremia Pulmonary Infection

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home or on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner
Date signed 2-10-48

60026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 60026

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5102 Wesley Ave.
(c) Hospital or institution: 28-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5102 Wesley Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry E. Huber, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-12-1050

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Brice R. Huber
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) July 15, 1888

8. AGE: Years	Months	Days	If less than one day
59	6	24	hr. min.

9. Birthplace Columbia, Pa.
(Town, county, and state)
10. Usual Occupation Asst. Lumber Agent
11. Industry or business B & O RR

FATHER
12. Name Ehrman Huber
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Flora Hull
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Harry E. Huber, Sr.
(b) Address 5102 Wesley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 11, 1948 (month) (day) (year)
(c) Cemetery or crematory Rock Run Cemetery
Location Havre de Grace, Md.

18 (a) Funeral director Willis Lemmon
(b) Address 4510 Liberty Heights Ave.

19 (a) FEB 10 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9 1948, at 8.45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7th 1948 to Feb. 9 1948 and that I last saw him alive on Feb. 9 1948.

Immediate cause of death

(a) Coronary Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: No

Duration
~~Unknown~~
2 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl J. Chambers M. D.
Address 4108 Liberty Hgts Ave Date signed 2/10/48.

VS 150

X

G60027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

110 B

Registered No. G60027

G.M. 117249

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 18-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 48 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 885 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Fernandiez or Henry A.J.A. Fernandes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29-1898

8. AGE: Years	Months	Days	If less than one day
49	1	9	hr. min.

9. Birthplace Spain (Town, county, and state)

10. Usual Occupation COAL MINER

11. Industry or business

FATHER
12. Name Anthony ?
13. Birthplace Spain

MOTHER
14. Maiden Name Lecryessa
15. Birthplace Spain

16 (a) Informant Records Balto. City Hpspials
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-11-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4200 Old Frederick Rd.

18 (a) Funeral director John J. Cannon & Son
(b) Address 901-03 Hollins St.

19 (a) FEB 10 1948 (Date rec'd by registrar) (b) Waiting for Affidavit Registrar

VS. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-7 1948, at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-6 1948, to 2-7 1948 and that I last saw h im alive on 2-7 1948.

Immediate cause of death	Duration
Respiratory Failure	
Due to Pneumonia Lobaire & Tuberculose Pleuretic, and	4 yrs.
Due to Chronic Pneumonitis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Robinson Jr. M. D.
Address Balt. City Hosp. Date signed 2/10/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

660028

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

33a

Registered No. 660028

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 153 W. Henrietta St
(c) Hospital or institution: 23-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 153 W. Hennetta St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cora Moses or Young

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-09-7535

4. Sex F.

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Chas. Moses.

6 (b) Name of husband or wife Chas. Moses.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 13-1911

8. AGE: Years 37 Months 0 Days 25 If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Oyster Shucker

11. Industry or business

FATHER 12. Name William Young.
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Nora Slater
15. Birthplace Balto. Md.

16 (a) Informant Hanna Goss
(b) Address 153 W. Henrietta St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 2 13 48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto.

18 (a) Funeral director Walter D. Long Co
(b) Address 139 W. Hamburg St.

19 (a) Date received by registrar FEB 14 1948 (b) Transit or burial permit No.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8 1948 at 0300

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1948 to 2/8 1948 and that I last saw h alive on 2/8 1948

Immediate cause of death Influenza — Duration 3 days

Due to Acute Bronchopneumonia — 7 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lincoln Shelton M. D.
Address 208 S. Sharp St Date signed 2/10/48

VS 150

G50029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G50029

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 21-1
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 Briscoe Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN MOSLEY

3 (b) If veteran, name war

3 (c) Social Security Account No. 228-05-2292

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation none.

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Rebecca Washer
(b) Address Va. Rout-1- Box 109

17 (a) (Burial, cremation, or removal) (b) Date thereof 2 11 48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto.

18 (a) Funeral director Walter B. Briggs
(b) Address 139 W. Hamburg St.

19 FEB 10 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7, 1948, at 3.50 a M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intra-cerebral P.J. Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L. Rogers M.D.
Medical Examiner
Date signed 2-7-48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

660030 X.G. 84780 — 107 — Registered No. 660030

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4-2
D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 658 W. Fairmont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George MORGAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28 1947

8. AGE: Years | Months: 6 | Days: 11 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George A. Heckstell
13. Birthplace Plymouth N.C.

MOTHER
14. Maiden Name Naomie Morgan
15. Birthplace Va.

16 (a) Informant Naomie B. Morgan
(b) Address 658 W. Fairmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 11, 1948 (month) (day) (year)
(c) Cemetery or crematory W. Lutheran Cem.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) Filed (Date received by registrar) (b) Waiting for Williams M.E.
FEB 10 1948

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8, 1948, at 5.25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑; accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 2/9/48

X

G60031

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. G60031

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1219 Madison Ave.
(c) Hospital or institution: 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1219 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wallace A. Heck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col	Married

6 (b) Name of husband or wife Minnie Heck

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 5 1893

8. AGE: Years	Months	Days	If less than one day
54	2	4	hr. min.

9. Birthplace Richmond Va. (Town, county, and state)

10. Usual Occupation Roofer

11. Industry or business

FATHER
12. Name Toney Heck
13. Birthplace Va.

MOTHER
14. Maiden Name Mary
15. Birthplace Randalls Va

16 (a) Informant Minnie Heck
(b) Address 1219 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 12 1948 (month) (day) (year)
Interment Mt Auburn Cem
Location

18 (a) Funeral director Louis E. Davenport
(b) Address 1006 Reisterstown Ave

19 (a) FEB 10 1948 (Date rec'd by registrar) (b) Interment for Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 Feb. 1948, at 9:45 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Hammer Jr. M.D. Medical Examiner
Date signed 7 Feb. 1948

VS 151

X

G60032 FF-02727 BALTIMORE CITY HEALTH DEPARTMENT ✓ G60032

GM. 117191 CERTIFICATE OF DEATH 159 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals 25-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) Life N.P.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2902 Round RD. Z 25 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BabyBoy Chase (Elaine)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 - 5 - 43

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Chase
13. Birthplace MD.

MOTHER
14. Maiden Name Elaine Bryant
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 11 1943 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cemetery
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) FEB 10 1943 (Date rec'd by registrar) (b) Burlington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 6 - 1943, at 5.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 - 5 1943, to 2 - 6 1943, and that I last saw him alive on 2 - 6 - 1943.

Immediate cause of death Prematurity — Duration 1 day

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Fetal atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arnold H Becker M. D.
Address Balto City Hosp Date signed 2/16/43

VS 150

X

0033 GM. 71634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 0033

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals 26-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 427 N. Highland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Sarah Campbell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1 -1892

8. AGE: Years	Months	Days	If less than one day
55	4	5	hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Michael
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Moore
15. Birthplace Ireland

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-11-48. (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Gem. Location 4701 Germans Mill Rd.

18 (a) Funeral director Charles L. Zeiler
(b) Address 901 S. Bonkskill St.

19 FEB 10 1948 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 6 - 1948, at 4.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2 - 5 - 1942, to 2 - 6 - 1948, and that I last saw her alive on 2 - 6 - 1948.

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Arteriosclerotic Hypertensive Cardiovascular Disease	
Due to	
Other Conditions Bronchopneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. L. Dearborn M.D. M. D.
Address Balto City Hosp. Date signed 2-9-48

660034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 660034

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 418 Gwynn Avenue
(c) Hospital or institution: 20-T
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 418 Gwynn Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EMMA M. SCHOOLHERR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	Widowed

6 (b) Name of husband or wife Lawrence Schoolherr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation house-wife
11. Industry or business

FATHER
12. Name Henry Bowers
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Helen R. Garvey
(b) Address 418 Gwynn Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland.

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) FEB 11 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8, 1948 19 , at 6.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 11, 1947, to Feb. 8, 1948, and that I last saw her alive on Feb. 7, 1948.

Immediate cause of death	Duration
Coronary thrombosis	11 mo.
Due to Arteriosclerotic-cardiovascular disease	?
Due to Diabetes mellitus	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George A. Kunkel M. D.
Address 3030 E. Monument Ave. Date signed 2/9/48

VS 150

G60035

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

49a

G60035
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 27-1
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3314 Beverly Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Edna Le Compte

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-14-1900

8. **AGE:** Years 47 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jacob Dyer
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Ashire
15. Birthplace Virginia

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Baltimore Co Md

18 (a) Funeral director Wilbur Cook Co
(b) Address 1210 Park Ave

19 (a) FEB 11 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-20 1948, to 2-10 1948, and that I last saw her alive on 2-10 1948

Immediate cause of death: UREMIA — Duration: 10 days

Due to: Malignant lymphoma

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation Jan 1946

Major findings of operation: Endometriosis, Rt Ovary

of autopsy: 2-10-48

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Sinex Hanson, M.D.
M. D.
Address Johns Hopkins Hosp Date signed 2-10-48

VS 150

G60036

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95c ✓

Registered No. G60036

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3549 Greenmount Ave.
(c) Hospital or institution: Home 9.3
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3549 Greenmount Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Belle Deal

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Louis Deal
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 5, 1867

8. AGE: Years	Months	Days	If less than one day
80	3	5	hr. min.

9. Birthplace Westmoreland Co. Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name David Kerr
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary E. Morrison
15. Birthplace Pa.

16 (a) Informant Elizabeth Deal
(b) Address 3549 Greenmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 13, 47 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Prospect Hill, Towson

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

FEB 11 1948 (Date rec'd by registrar) Huntington for Williams M.R.

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH Feb. 10 1948, at 3:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/9 1948, to 2/10 1948.
and that I last saw h[illegible] alive on 2/9 1948.

Immediate cause of death	Duration
Cardiac dilatation	4 hours
Due to pulmonary & general edema	
Due to age - Obesity -	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry W. McCarty, M.D.
Address 87 W. Preston St Date signed 2/10/48

VS 153

X

G60037

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 54 B

G60037 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3004 Darley Street # 11
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elva Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-4386

4 Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife William Cooper

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1894

8. AGE: Years 53 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Co Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER | FATHER

12. Name George M Walker

13. Birthplace Balto Co.

14. Maiden Name Virginia Tracey

15. Birthplace Balto Co.

16 (a) Informant Wm Cooper

(b) Address 3004 Darley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-11-48 (month) (day) (year)

(c) Cemetery or crematory Poplar Grove Church
Location Warren Balto Co

18 (a) Funeral director Frank H Seitz

(b) Address 1414 36 St

19 (a) FEB 11 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/7/48 19 . at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1/47 19 to 2/7/47 19 , and that I last saw h[illegible] alive on 2/7/47 19 .

Immediate cause of death Coma
Failure

Due to Hemorrhage
Compression

Due to Intracranial tumor
from cerebral neoplasm

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2/3/48

Major findings of operation: tumor
left hemisphere

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John White M.D.

Address University Hosp. Date signed 2/7/48

VS 150

X

G60038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G60038 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27-15
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4308 Falls Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Lee Wheeler

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2-1879

8. AGE: Years 69 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

MOTHER — FATHER

12. Name William M. Wheeler

13. Birthplace Maryland

14. Maiden Name Annie Rebecca Carbon

15. Birthplace Maryland

16 (a) Informant Miss Eva Jane Wheeler

(b) Address 4308 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 12-1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Marys Lampden

Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road

19 (a) FEB 11 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9, 1948, at 7 P. M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Headley M.D. Medical Examiner.

Date signed 2-10-48

VS 181

G60039

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 47

G60039
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raynor
(c) Hospital or institution: West Balto. Gen. Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 94 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2732 Wilkens Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Schelsky

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-0008

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife NELLIE (DOWD)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 5 1900

8. AGE: Years	Months	Days	If less than one day
47	7	4	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Paint Sprayer
11. Industry or business CHARLES F BRANDT

FATHER
12. Name ADAM SCHELSKY
13. Birthplace ?

MOTHER
14. Maiden Name LILLIAN -
15. Birthplace ?

16 (a) Informant MRS ALBERT SCHELSKY
(b) Address 2732 WILKENS AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Feb. 13 1948 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location OLD FREDERICK RD

18 (a) Funeral director Harry A Wiegle
(b) Address 4101 Edmondson Ave

19 (a) FEB 11 1948 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 February 1948, at 9:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/7 1947 to 2/9 1948 and that I last saw h[illegible] m alive on 2/9 1948.

Immediate cause of death Carcinoma of Lung

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 12/18/47

Major findings of operation: Carcinoma of Rt. Lung

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas M. Checket
Address W. Balto. Gen Hosp. Date signed 2/9/48

VS 150

C60040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

Registered No. C60040

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1632 N. Durham St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 + 6

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1632 N. Durham St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carolyn E. Charnick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Edward L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1925

8. AGE: Years	Months	Days	If less than one day
22	6	16	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Ernest T. Nittinger
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Virgina F. Smith
15. Birthplace Eastern Shore Md.

16 (a) Informant Edward L. Charnick
(b) Address 1632 N. Durham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/48 (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

FEB 11 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 February 1948, at 6:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to Feb 1948, and that I last saw her alive on 7 Feb 1948.

	Duration
Immediate cause of death: Heart Failure	1 wk
Due to: Rheumatic Heart Disease	15 years
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Roy M. Zimmerman M.D.

Address 2858 Howard St. Date signed 9 Feb. 48 M.D.

VS 150

G60041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G60041

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner and Dukeland St.
(c) Hospital or institution: West Balt. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balt. 14.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3011 Lemmond Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Linda Hever

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/8/48

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Balt. Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert Hever
13. Birthplace Balt. Md.

MOTHER
14. Maiden Name Dorothy Ritter
15. Birthplace Balt. Md.

16 (a) Informant Dorothy Hever
(b) Address 3011 Lemmond Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-11-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair

18 (a) Funeral director Clarence E. Hoffmann
(b) Address 1639 N. Broadway

19 (a) FEB 11 1948 (Date rec'd by Registrar) (b) Lucian Williams (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9 1948 at 10:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 8 1948 to Feb 9 1948 and that I last saw her alive on FEB. 9 1948.

Immediate cause of death	Duration
PREMATURITY	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Francis L. Grumbine M. D.
Address W. Balt. Gen. Hosp. Date signed Feb 10, 48

VS 150

G60042

BALTIMORE CITY HEALTH DEPARTMENT

BC-48-02976 CERTIFICATE OF DEATH 159

G60042
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 6-1

(a) Baltimore City, Maryland

(b) Street address Calhoun & Fayette

(c) Hospital or institution: Franklin Square

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 410 N. CURLEY ST
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Girlando, Baby Girl (GIRLANDO)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-4-48

8. AGE: Years	Months	Days	If less than one day
		2 6	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Joseph Girlando

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Alda PETRILLI

15. Birthplace Balt. Md

16 (a) Informant Mother Chas

(b) Address

17 (a) Burial (b) Date thereof 2/11-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory HOLY REDEEMER
Location 13 CLAIR RD BALT. MD

18 (a) Funeral director Frank Della Noce

(b) Address 52 N. Morley St

FEB 11 1948 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-10 1948, at 1.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-4 1948 to 2-10 1948 and that I last saw h[illegible] alive on 2-10 1948

Immediate cause of death Marasmus Atelectasis

Due to

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Marcia

Address Franklin Square Hosp. M. D.

Date signed 2-10-48

161a

G60043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G60043 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland 27-2

(b) Street address Edward & Green St.

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 45

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 4513 Mansfield (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME French, Edna May

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife George Nelson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24-1883

8. AGE: Years 64 Months 8 Days 16 If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Oliver J. Wright

13. Birthplace Md

MOTHER 14. Maiden Name Ella J. Reay

15. Birthplace Danville, Va.

16 (a) Informant Mrs. Oliver Wright

(b) Address 4513 Mansfield

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto

18 (a) Funeral director L. J. Luck

(b) Address 5305 Harford Rd.

19 (a) FEB 11 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9 1948 at 8 39 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1948 to Feb 9 1948 and that I last saw h[illegible] alive on Feb 9 1948

Immediate cause of death Lung pulmonary edema

Due to Cardiac Lt ventricular heart failure

Due to

Other Conditions Hypertension, Coronary sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature [illegible] Jr

Address Univ. Hosp. Date signed 2/9/48 M.D.

VS 150

Dr. Lachman
4930 Belair Road

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46E

Registered No. G60044

G50044

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5105 Edgar Terrace
(c) Hospital or institution: 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5105 Edgar Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernesta Franzoni

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Aristide Franzoni
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1872

8. AGE: Years	Months	Days	If less than one day
75	5	19	hr. min.

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ? Dell'amico
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace Italy

16 (a) Informant Mrs. George Eikenberg
(b) Address 5105 Edgar Terrace

17 (a) Burial (b) Date thereof 2-11-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) FEB 11 1948 (Date rec'd by registrar) Huntington Williams Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8, 1948, at 5P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1947 to Feb 8 1948, and that I last saw b[illegible] alive on Feb 8 1948

Immediate cause of death	Duration
Myocarditis	3 yrs
Due to Generalized Arteriosclerosis	10 y
Due to	
Other Conditions Carcinoma of Colon	2 yr

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Lachman
Address 4930 Belair Rd Date signed Feb 9, 1948

VS 150

X

G60045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G60045 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 304 N Robinson St
(c) Hospital or institution: 6-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 304 N Robinson
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Laughlin

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband Marion Laughlin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2 1863

8. AGE: Years	Months	Days	If less than one day
84	5	8	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business Gr House

FATHER
12. Name Leo Lemmes
13. Birthplace Germany

MOTHER
14. Maiden Name Dora Kraus
15. Birthplace Germany

16 (a) Informant Leo Lemmes
(b) Address 3083 E Monument

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans

FEB 11 1948 (Date rec'd by registrar)
(b) J. Huntington Williams M.D. Registrar

VS - 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9/48 19 , at 12 ½ M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-24-46 19 , to 2-9- 1948, and that I last saw h alive on 2-8- 1948.

Immediate cause of death	Duration
Arteriosclerotic heart disease	3 years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benj. B. Moses M.D.
M. D.
Address 448 N. Luzerne Ave Date signed 2-9-48

X

G60046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161c

G60046

Registered No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address South Balt. Gen. Hosp.

(c) Hospital or institution 1213 Light St, Balt. 30, Md.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balt.

(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)

(d) Street No. Hosp - South Balt. Gen. Hosp. 21 Postal Rd (If rural give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Grace

3 (b) If veteran, name war? none

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/5/48

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Baltimore 30 Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER

12. Name William S. L. Grace Jr.

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Frances Berry

15. Birthplace New Concord, Ohio

16 (a) Informant Hospital records

(b) Address 1213 Light St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 9th (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem

Location City

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2006 Arlington Ave

19 (a) Feb 11 1948 (Date rec'd by registrar) (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8 1948, at 10 55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5 1948 to Feb 8 1948, and that I last saw him alive on Feb 8 1948.

Immediate cause of death Cyanosis, Anasarca, Hemadenitis

Due to Sclerema

Due to

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: ✓

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?

(e) Means of injury

23. Signature James Brown

Address 705 Medical arts Date signed 2/8/48

VS 150

G60047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G60047

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 902 N Luzerne Ave
(c) Hospital or institution: T-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 902 N Luzerne Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie Gertrude Renshaw

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Henry Renshaw
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Oct 27 187[illegible]

8. AGE: Years	Months	Days	If less than one day
74	3	11	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation
11. Industry or business At home

FATHER
12. Name John A Kennard
13. Birthplace Balto

MOTHER
14. Maiden Name Dorothea Penn
15. Birthplace Balto

16 (a) Informant Henry Renshaw
(b) Address 902 N Luzerne St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/48 (month, day, year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2006 Orleans St

19 (a) [illegible] (Date rec'd by registrar) Municipal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/8/48 19 , at 1:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/4 1948 to 2/8 1948, and that I last saw her alive on 2/8 1948.

Immediate cause of death	Duration
Gangrene of leg.	2 weeks
Due to Diabetes Mellitus.	
Due to	
Other Conditions Arteriosclerosis Cardio-Vascular-Renal Disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James S. Blum M. D.
Address 2006 Eutaw St Date signed 2/8/48

VS 150

660048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1330

660048 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 3.1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 E. Balto St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MRS. JENNIE NATHANSON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Benjamin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 46 | Months | Days | If less than one day hr. min.

9. Birthplace Romania (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Not Known

13. Birthplace Romania

MOTHER 14. Maiden Name Rebecca

15 Birthplace Romania

16 (a) Informant Benjamin Nathanson

(b) Address 1417 E Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-11-48 (month) (day) (year)

(c) Cemetery or crematory Hebrew Mt Carmel

Location

18 (a) Funeral director Jack Lewis Inc

(b) Address 760 Eutaw Place

19 FEB 11 1948 Huntington Williams Funeral

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10 1948 at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from JAN. 19 1948 to Feb 10 1948 and that I last saw h[illegible] alive on Feb 10 1948

Immediate cause of death	Duration
Uremia	
Due to Polycystic Kidneys	
Due to	
Other Conditions Pulmonary Edema	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Allan J. Wolinsky M. D.

Address Sinai Hospital Date signed 2-11-48

VS 150

C60049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

176

Registered No. C60049

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 934 Madison Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LOUIS LEE FLEET

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Esther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 5, 1904

8. AGE: Years 44 | Months 1 | Days 3 | If less than one day hr. min.

9. Birthplace: Balto. Md (Town, county, and state)

10. Usual Occupation: Longshoreman

11. Industry or business:

FATHER
12. Name: Louis Fleet
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Agnes ?
15. Birthplace: Maryland

16 (a) Informant: Mrs. Esther Fleet
(b) Address: 934 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 11, 1948 (month) (day) (year)
(c) Cemetery or crematory: Gibbons Mem. Pk.
Location: Baltimore Co. Md.

18 (a) Funeral director: Mrs. Geo. H. Stollard
(b) Address: 1631 Druid Hill Ave

19 (a) FEB 11 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8, 1948, at 2.40 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coupled Palsies
Pulmonary Edema
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-8-48 at about 2 a. M. 2616
(b) Where did injury occur? Pier #1 Clinton St. Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury: Struck by boom

23. Signature Emil Kruger M.D. Medical Examiner
Date signed 2-9-48

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 060050

060050

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1712 N. Calhoun Street
(c) Hospital or institution: 151
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 1712 N. Calhoun St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Augustus N. WEEMS

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-14-8851

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Julia M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1875

8. AGE: Years 72 | Months 6 | Days 12 | If less than one day hr. min.

9. Birthplace MONTGOMERY Co. MD.
(Town, county, and state)

10. Usual Occupation CUSTODIAN

11. Industry or business

FATHER
12. Name BENJAMIN F. WEEMS
13. Birthplace MONTGOMERY Co. MD.

MOTHER
14. Maiden Name ELIZA HUTCHINSON
15. Birthplace MONTGOMERY Co. MD.

16 (a) Informant Julia M. WEEMS
(b) Address 1712 N. CALHOUN ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 13, 1948 (month) (day) (year)
(c) Cemetery or crematory Rocky Hill
Location Montgomery Co. Md.

18 (a) Funeral director Hub. Geo. H. Hulfish
(b) Address 1631 Druid Hill Ave.

19 (a) FEB 11 1948 (Date rec'd by Reg.) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9, 1948, at 11 A.M.

21. I certify that I took charge of the remains described above, held an Inspection + Exam. Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George B. Merrill M.D.
Medical Examiner.
Date signed 2/9/48

VS 181

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G60051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G60051

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3903 Old York Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) --

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3903 Old York Rd.
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) **FULL NAME** HENRIETTA PFAFF

3 (b) If veteran, name war	3 (c) Social Security Account No.
*W**	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 3, 1856

8. AGE: Years	Months	Days	If less than one day
91	10	4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business --

FATHER
12. Name George Pfaff
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Noll
15. Birthplace Germany

16 (a) Informant Mr. Frederick Singley
(b) Address Md. Trust Bldg.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/48 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Greenmount
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address Baltimore, Md.

19 FEB 11 1948 Huntington Williams, M.D.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7, 1948 19..., at 9:45P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1948 to Feb 7 1948 and that I last saw h[illegible] alive on Feb 7 1948.

Immediate cause of death	Duration
Lobar Pneumonia	1948
Due to	
Due to	
Other Conditions Acute Cardiac Dilatation	1948

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. W. Bishop M. D.
Address 523 Sheldon Ct Date signed Feb 9

GC0052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. GC0052

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4303 Groveland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs +

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore, 7 (If outside city or town limits, write RURAL and give town)
(d) Street No. 4303 Groveland Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD FELIX HOFFMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Florence May
6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr) June 6, 1856

8. AGE: Years	Months	Days	If less than one day
91	8	4	hr. min.

9. Birthplace Louisville, Kentucky (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Harness makey

FATHER
12. Name
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Festey
15. Birthplace

16 (a) Informant Edward Felix Hoffman, Jr.
(b) Address 11 W. Mount Vernon Pl, Balt. 1,

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/13/48 (month) (day) (year)
(c) Cemetery or crematory LOUDEN PK.
Location BALTIMORE MD.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves., Balto; Md.

19 (a) FEB 11 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10 1948, at 1:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from February 6 1948 to February 10 1948, and that I last saw him alive on February 9 1948.

Immediate cause of death: Congestive Heart Failure — Duration: 4 days
Due to Arteriosclerotic cardio-vascular renal disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Millard T. Tralondh. M.D.
Address 3400 Woodbine Ave, 7, Date signed Feb 11 48

VS 150

G60053

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G60053
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address XXXX 2211W Rogers Ave.
(c) Hospital or institution:
Home for the Aged of the Methodist Church
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

27-15

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211W. Rogers Ave.
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME ELIZA J. BRODBECK

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife: Franklyn Brodbeck
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Jul. 7, 1853

8. AGE: Years	Months	Days	If less than one day
94	7	2	____ hr. ____ min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business --

FATHER
12. Name Kean Curry
13. Birthplace Maryland

MOTHER
14. Maiden Name Eliza Koller
15. Birthplace Penna.

16 (a) Informant Katherine F. Wimmer
(b) Address 200 Frederick Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/48 (month) (day) (year)
(c) Cemetery or crematory XXXX Friends Burial Ground.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves; Balto., Md.

19 (a) FEB 11 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9, 1948 19__, at 5.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1948 to Feb 8 1948 and that I last saw h__ alive on Feb 8 1948.

Immediate cause of death	Duration
Myocardial Insufficiency	5 days
Due to	
Due to Arteriosclerosis	20 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Audrey J. Davies M. D.
Address 5000 Wabash Ave Date signed 2/10/48

VS 150

G60054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. G60054

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 S. Montford Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 to 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 600 South Montford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Stankiewicz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~or wife~~ Bronislaw

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) April 1898

8. AGE: Years	Months	Days	If less than one day
49	10		....hr. ....min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Michael Kogut
13. Birthplace Poland

MOTHER
14. Maiden Name Sophia Bialek
15. Birthplace Poland

16 (a) Informant Bronislaw Stankiewicz
(b) Address 600 South Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ ST. STANISLAUS
Location BALTIMORE Md

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street

19 FEB 11 1948 (Date rec'd by Registrar) (Huntington Williams Md)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9th 1948, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 12 1948 to Feb 9 1948, and that I last saw h[illegible] alive on Feb. 9 1948.

Immediate cause of death Carcinoma of Lung Metastatic Carcinoma of Liver — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel B. Wolfe, M. D.
Address 1331 E. Fort Ave Date signed 2-10-48

V S 150

660055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 660055

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3629 Kimble Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3629 Kimble Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie G. Roche

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Thomas A. Roche
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12, 1878

8. AGE: Years	Months	Days	If less than one day
70	0	28	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife at home
11. Industry or business

MOTHER — FATHER

12. Name Jerusha Annie Valle
13. Birthplace Germany
14. Maiden Name Catherine Cunningham
15. Birthplace Germany

16 (a) Informant Mr. James M. Roche
(b) Address 3629 Kimble Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 13, 1948 (month) (day) (year)
(c) Cemetery or crematory Mount Calvary Cemetery
Location 4300 Old Frederick Rd.

18 (a) Funeral director Edmund W. Conklin & Son
(b) Address 924 E. Eager St.

FEB 11 1948 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10th, 1948, at 12½ M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1947, to Feb 9 1948, and that I last saw h.e.r. alive on Feb 9 1948.

Immediate cause of death	Duration
Carcinoma of the stomach	unknown
Due to	
Due to	
Other Conditions. Bronchopneumonia	2 weeks

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury W. C. Dunnigan

23. Signature M. D.
Address 31 E North Ave Date signed 2/10/48

660056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

660056
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1141 Sargeant Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Frank Zinkand

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Nellie Zinkand
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1900

8. AGE: Years	Months	Days	If less than one day
47	10	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Chauffer
11. Industry or business City Express

FATHER
12. Name Joseph Zinkand
13. Birthplace Baltimore

MOTHER
14. Maiden Name Henrietta Graef
15. Birthplace Balto Md.

16 (a) Informant Mrs Nellie Zinkand
(b) Address 1141 Sargeant St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Mem.
Location Rt Ohio Blvd
18 (a) Funeral director Gold Cowan & Son
(b) Address 901-03 Holliday St.
19 (a) 2-14-1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/10/48 19 , at 2-15 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 2/2 19 48 to 2/10 19 48, and that I last saw h I M alive on 2/10 19 48

Immediate cause of death	Duration
Acute Coronary Insufficency	
Due to Myocardial Infarction	
Due to Coronary Occlusion	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Gilbert M. Carouge M. D.
Address 6226 Everall Ave. Date signed 2/10/48

VS 150

G60057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G60057 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Alameda Home & Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2802 Alameda Blvd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. James Wilmer

3 (b) If veteran, name war: no

3 (c) Social Security Account No.:

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mrs. Ada Wilmer

6 (c) If alive, give age, years

7. Birth date of deceased (mo., day, yr.) 2/18/1874

8. AGE: Years 74 | Months 11 | Days 21 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation retired (clerk)

11. Industry or business

FATHER 12. Name James Wilmer

13. Birthplace Maryland

MOTHER 14. Maiden Name Helena S. Hoffman

15. Birthplace Maryland

16 (a) Informant Mrs. James Wilmer

(b) Address 2802 Alameda Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 12 1948 (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Oliver & Greenmount Ave

18 (a) Funeral director Leo G. Cook

(b) Address 1701-03 N. Patterson Park Ave

19 (a) (Date received by registrar) (b) Transcription for Williamsburg, Md. Registrar

FEB 14 1948

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9/48 19 , at 7 35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/8/48 19 to 2/9/48, and that I last saw him alive on 2/9/48.

Immediate cause of death: Asthenia Coronary thrombosis

Due to: Pulmonary infarct, R.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: none

of autopsy: none

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph D. Gatonis M.D.

Address Alameda Home & Hosp. Date signed 2/9/48

X

G60058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

180

G60058
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1306- Bonaparte Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: LINCOLN G. FELTY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: [redacted]

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15th 1899

8. AGE: Years 48 | Months 3 | Days 24 | If less than one day hr. min.

9. Birthplace Philadelphia Penn
(Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business Coastal Tank Line

FATHER
12. Name Harry Felty
13. Birthplace Penna

MOTHER
14. Maiden Name Sarah Rife
15. Birthplace Penna

16 (a) Informant Mrs D. Felty
(b) Address 1306 Bonaparte Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 13th 1948 (month) (day) (year)
(c) Cemetery or crematory Lorraine Mem.
Location Ten Hills

18 (a) Funeral director Leo S. Cook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) (b) Wm. A. Williams M.D.
(Date received by registrar) (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9, 1948, at 3.20 P M

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
2nd, 3rd, degree burns of body

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 9/7

(a) Date of injury 2-9-48 at 3.10 p. M.
(b) Where did injury occur? Atlantic Coastal Tank Line 2504 Harford Road.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury. Explosion

23. Signature [signature] M.D.
Medical Examiner

Date signed 2-10-48

G60059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

309

G60059
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1103 Steelton st (If rural give location)
(e) Citizen of foreign country? Steelton st (or No)
If yes, name country

3 (a) FULL NAME Frank Lamios

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1878
8. AGE: Years 70 | Months | Days | If less than one day hr. min.
9. Birthplace Greece (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant James Thurman
(b) Address 1103 Steelton st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-11-48 (month) (day) (year)
(c) Cemetery or crematory Greek Cemetery
Location Woodlawn Mill Rd

18 (a) Funeral director Lambros & Homan
(b) Address 440 E. North ave

Washington Williams M.D.
(Date rec'd by registrar) Registrar

FEB 11 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/4 1948, at 10 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/4 1948 to 2/4 1948 and that I last saw h/m alive on 2/4/48 19

Immediate cause of death: Cardiac Decompensation
Due to: Gangrene of small & large bowel
Due to:
Other Conditions: Lues (treated)
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Arteriosclerotic HT Disease - gangrene of bowel - Norris Hendrix

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature
Address Sinai Hosp Date signed 2/11/48 M. D.

92 a

G60060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G60060

81a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene

(c) Hospital or institution: University of Maryland Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Talbott

(c) City or town Easton (If outside city or town limits, write RURAL and give town)

(d) Street No. Box 377 (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Elvon Cephus.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Hester

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1840

8. AGE: Years	Months	Days	If less than one day
5 8			hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business

FATHER 12. Name Moses Cephus

13. Birthplace

MOTHER 14. Maiden Name Emma Bosley

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-48 (month) (day) (year)

(c) Cemetery or crematory Richardson

Location Talbot County Md.

18 (a) Funeral director Earl W. Stafford

(b) Address Easton Md.

19 (a) FEB 11 1948 (Date rec'd by registrar) (b) Huntington for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1948, at 12:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/27 1948 to 2/10 1948 and that I last saw him alive on 2/10 1948

Immediate cause of death	Duration
Embolism - respiratory collapse.	
Due to Encephalomalacia, Septicemia " Meningitis	
Due to	
Other Conditions Chr. Cardiac.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C N Taylor M. D.

Address Redwood & Greene Date signed 2/10/48

VS 150

Dr. Gladden
2700 N. Calvert St.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

660061 ✓ Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1414 N. Patterson Park
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 N. Patterson Park
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Oberle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Anna M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 14, 1887

8. AGE: Years	Months	Days	If less than one day
60	3	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Fire Department
11. Industry or business

FATHER
12. Name John Oberle
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Arras
15. Birthplace Germany

16 (a) Informant Mrs. Anna M. Oberle
(b) Address 1414 N. Patterson Park

17 (a) Burial (b) Date thereof 2-12-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) 2-11-1948 (b)
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9, 1948, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1, 1947 to Feb. 9, 1948. and that I last saw him alive on Feb. 7, 1948.

Immediate cause of death	Duration
Coronary occlusion	5 months
Due to Coronary Artery sclerosis	over 4 yrs.
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ~
(b) Date of occurrence ~ at ~ M
(c) Where did injury occur? ~
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ~ While at work? ~
(Specify type of place)
(e) Means of injury

23. Signature Frank H. Ogden M. D.
Address 2701 N. Calvert St Date signed Feb. 11, 48

VS 150

Huntington Williams, M.D.

X

G60062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G60062

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3729 Nortonia D.O.A. Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3729 Nortonia Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W Backer

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 216-14-1321

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife: MARY ASKEW

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 21, 1890

8. AGE: Years	Months	Days	If less than one day
57	11	9/17	hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation ASS'T TREAS.

11. Industry or business BALTO. NAT'L BNK.

FATHER
12. Name JOHN W. BACKER
13. Birthplace GERMANY

MOTHER
14. Maiden Name ELIZEBETH KAHLER
15. Birthplace BALTIMORE, MD.

16 (a) Informant MRS. MARY ASKEW BACKER
(b) Address 3729 NORTONIA RD.

17 (a) X BURIAL (Burial, cremation, or removal) (b) Date thereof 2/13/46 (month) (day) (year)

(c) Cemetery or ~~crematory~~ LOUDON PK.
Location BALTIMORE, MD.

18 (a) Funeral director WM. J. TURNER & SONS INC.
(b) Address BALTIMORE, MD.

19 (a) FEB 11 1948 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/10 1948, at 6:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 2/10/48

X

G60063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G60068

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Union Memorial Hosp.
(c) ~~Hospital or institution~~: 33rd & Calvert St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 Aintree Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** EMIL A. LEHNERT

3 (b) If veteran, name war: NONE

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	WIDOWED

6 (b) Name of husband or wife JULIA RAABE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 8, 1871

8. AGE: Years	Months	Days	If less than one day
76	6	2	hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation PARTNER - WAGON BUSINESS

11. Industry or business —

FATHER
12. Name ERNEST LEHNERT
13. Birthplace GERMANY

MOTHER
14. Maiden Name MOHLMEYER
15. Birthplace

16 (a) Informant —
(b) Address —

17 (a) BURIAL (b) Date thereof 2/13/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON PK.
Location BALTIMORE, MD.

18 (a) Funeral director WM. T. TICKNER & SONS
(b) Address BALTIMORE, MD.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

FEB 11 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10 1948, at 12:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1948 to Feb 10 1948, and that I last saw h/AM alive on Feb 10 1948

Immediate cause of death	Duration
Myocardial Infarction	1 da
Congestive Heart Failure	
Due to Arteriosclerotic Heart	—
Due to Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman M.D.

Address Union Memorial Hosp. Date signed 2/13/48

X

G60064 ✓ G60064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D O A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2013- Edgewood Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY G. STANLEY

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
None	None	Female	White	Married

6 (b) Name of husband or wife Willard FRANKLIN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1893

8. AGE: Years	Months	Days	If less than one day
54	4	13	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business --

FATHER
12. Name David L. McPherson
13. Birthplace 2013 Edgewood St.

MOTHER
14. Maiden Name Eva Hooper
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Helen McPherson
(b) Address 2013 Edgewood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ New Cathedral
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves; Balto., Md.

FEB 11 19 (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10, 1948, at 2.25 P M

21. I certify that I took charge of the remains described above, held an aut psy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon monoxide poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-10-48 at 1.35 P. M. 2013 Edgewood St.
(b) Where did injury occur? Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Gas stove, burners on, unlit.

23. Signature Earl L. Kaylen M.D. Medical Examiner.
Date signed 2-11-48

VS 181

G60065

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1312

Registered No. G60065

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Venetia (If outside city or town limits, write RURAL and give town)
(d) Street No. R.D. #1 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Drain

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Marie
6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) 2-12-12

8. AGE: Years	Months	Days	If less than one day
35	11	24	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation ~~Service station attendant~~
11. Industry or business Coal Mines H.C. Frick

FATHER
12. Name Alexander Drain
13. Birthplace Russia

MOTHER
14. Maiden Name Katherine Kutellar
15. Birthplace Russia

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~
Location Bridgeville, Pa.

18 (a) Funeral director John O. Mitchell & Sons Inc.
(b) Address 1900 Eutaw Place

19 (a) FEB 1 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11 1948, at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 13 1948 to Feb. 11 1948 and that I last saw him alive on Feb. 11 1948

Immediate cause of death Uremia — Duration 4 mo

Due to Chronic Glomerulonephritis — Duration 4 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Douglas Carroll M.D.
Address Johns Hopkins Hosp. Date signed Feb 14

M. D. B. 1201-0

G60066

HEALTH DEPARTMENT—CITY OF BALTIMORE

G60066

CERTIFICATE OF DEATH

108

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount + Hollins Sts St., 15-1 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME Sr. Magdalen of St. Dominic (Annie Taylor)

(a) Residence: No. Mount + Hollins Sts St., ... Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F.	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, year) 2/10 1871

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	—	—	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Sewing and

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. domestic work

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation 58

12. BIRTHPLACE (city or town) (State or country) Westminster, Md.

FATHER

13. NAME James Taylor

14. BIRTHPLACE (city or town) (State or country) N. K. Known

MOTHER

15. MAIDEN NAME Susan Cummins

16. BIRTHPLACE (city or town) (State or country) Not Known

17. INFORMANT Home of Good Shepherd (Address) Mount + Hollins Sts.

18. BURIAL, CREMATION, OR REMOVAL Place Cathedral Date 2/10/48 19..

19. UNDERTAKER J. J. Fahey + Sons (Address) 3 & 8 Light St.

20. FILED FEB 11 1948 Thurlington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Feb 10, 1948

22. I HEREBY CERTIFY, That I attended deceased from Jan 28, 1948, to Feb 9, 1948

I last saw her alive on Feb 9, 1948. Death is said to have occurred on the date stated above, at 10 A m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Lobar Pneumonia	2/5/48
Other contributory causes of importance:	
Cardiac Asthma	4yrs

Name of operation — Date of —

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19..

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify .....

(Signed) Jos A Manos M. D.

(Address) 1800 N Charles St

information should be carefully supplied. AGE should be given EXACTLY. If unknown, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G60067 BALTIMORE CITY HEALTH DEPARTMENT G60067
Registered No.

CERTIFICATE OF DEATH

46E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N C (b) County
(c) City or town Goldsboro (If outside city or town limits, write RURAL and give town)
(d) Street No. 611 Park Ave (if rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lionel Weil

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jeannette
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-1-77

8. AGE: Years 70 | Months 5 | Days 10 | If less than one day hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER 12. Name Soloman Weil
13. Birthplace Germany

MOTHER 14. Maiden Name Sara Einstein
15. Birthplace Mass.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/14/48 (month) (day) (year)
(c) Cemetery or crematory Goldsboro.
Location Goldsboro N C

18 (a) Funeral director Wilson & Dail
(b) Address 129 E Cord St

19 (a) FEB 1 1948 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1948, at 11 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to Feb 11 1948, and that I last saw him alive on Feb 11 1948.

Immediate cause of death	Duration
Carcinomatosis	
Due to	
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rowena Spencer M.D.
Address Johns Hopkins Hosp Date signed 2-11-48 M. D.

VS 150

G60068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G60068
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2618 Shirley Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2618 Shirley Ave (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Minna C. Burkart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	Widowed

6 (b) Name of husband or wife Rea. John J.
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr) Mar. 24-74

8. AGE: Years	Months	Days	If less than one day
73	10	15	hr. min.

9. Birthplace Baltimore - Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name John H. Schnepfe
13. Birthplace Germany

MOTHER
14. Maiden Name Anna C. Schuartz
15. Birthplace Germany

16 (a) Informant Miss. Mary C. Burkart
(b) Address 2618 Shirley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 Feb 48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balt. Md.

18 (a) Funeral director J. R. Wiseburt & Son
(b) Address 1800 Eutaw Pl

19 (a) (Registrar) (b) Registrar

FEB 12 1948
VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/8 1948 at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 8 1948 to Feb. 8 1948, and that I last saw her alive on Feb. 8 1948.

Immediate cause of death	Duration
Coronary Thrombosis	12 hrs
Due to Cardiac Arteriosclerosis	yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James E. Akehurst M. D.
Address 2412 Park Hgts. Date signed 2-10-48

X

G60069

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G60069 Registered No. 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Cold Spring Lane
(c) Hospital or institution:
Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Fullerton, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Fitch Ave., #496
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM E. FOLTZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Minnie Meter Foltz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11th, 1866

8. AGE: Years	Months	Days	If less than one day
81	10	29	hr. min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)

10. Usual Occupation Truck Farmer

11. Industry or business

FATHER
12. Name Daniel Foltz
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Wm. E. Fitch
(b) Address Fitch Ave., #496

17 (a) burial (b) Date thereof 2/13/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Zion Lutheran
Location Stemmers Run, Md.

18 (a) Funeral director Lapsley Funeral Home
(b) Address 7491 Belair Road

19 (a) FEB 11 1948 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1948 at 8.30 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1948 to Feb 10 1948.
and that I last saw him alive on Feb 1 1948.

Immediate cause of death — Duration

Acute Myocardial Disease — 2 d

Due to Arteriosclerosis — 1 y

Due to

Other Conditions.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Otho Thurlow M. D.

Address 4116 Northern Pkwy Date signed 2-11-48

VS 150

G60070 ✓ G60070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 66B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Edmund & Greene Sts.
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 Aisquith St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Comer, Robert F.

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	M.

6 (b) Name of husband or wife Mary V. Comer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 19th 1908

8. AGE: Years	Months	Days	If less than one day
39	5	21	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Charles Comer
13. Birthplace Virginia

MOTHER
14. Maiden Name Clara Coulter
15. Birthplace Virginia

16 (a) Informant Mary V. Comer
(b) Address 1612 Aisquith St

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/13/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) FEB 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1948, at 2:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/9 1948 to 2/10 1948, and that I last saw him alive on 2/10 1948.

	Duration
Immediate cause of death Pulmonary edema	
Due to Left ventricular failure	
Due to Hypertension & obesity	
Other Conditions Severe obesity.	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signature C. W. Lyerton M. D.
Address Univ. Hosp. Date signed 2-13-48

X

660071

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

660071
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1934 Preston St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1934 Preston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Mary Webb

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Wm. H. Webb

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 20 1874

8. AGE: Years 73 | Months 4 | Days 15 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Charles Rokney

13. Birthplace Md

14. Maiden Name Lucinda Smith

15. Birthplace Md

16 (a) Informant Pearl Rasch

(b) Address 3931 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/48 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet Md

Location Baltimore Md

18 (a) Funeral director Wilson & Son

(b) Address 1210 E Fayette St

19 (a) FEB 11 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1948, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1948 to Feb 10 1948 and that I last saw her alive on Feb 10 1948.

Immediate cause of death: Cerebral Hemorrhage (Apoplexy) — Duration 24 Hours Undetermined

Due to: Hypertension & Arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alfred Cole M.D.

Address 1934 Wilkens Ave Date signed 2-11-48

X

G660072

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. G660072

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 Light Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH LIPPIE

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-22-7073

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mrs Lippie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 15 1895

8. AGE: Years 52 | Months 2 | Days 24 | If less than one day hr. min.

9. Birthplace Shamokin, Pa (Town, county, and state)

10. Usual Occupation

11. Industry or business Maryland Dry Dock

FATHER
12. Name Unknown Lippi
13. Birthplace Pa

MOTHER
14. Maiden Name Unknown
15. Birthplace Pa

16 (a) Informant Ellsworth Libby
(b) Address 1450 N State St, Shamokin Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie Md

18 (a) Funeral director Wilhoyte & Co
(b) Address 1219 E Fayette St

19 (a) FEB 12 1948 (Date rec'd by registrar) (b) Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9, 1948, at 4.20 A M

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl E Royer M.D. Medical Examiner.
Date signed 2-9-48

X

G60073

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 477

G60073
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga Sts.
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore #14
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2612 Hermosa Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert J. N. DeLane

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Wh.	Married

6 (b) Name of husband or wife Mrs. Rose DeLane
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1884

8. AGE: Years	Months	Days	If less than one day
63	8	2	hr. min.

9. Birthplace England
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name James DeLane
13. Birthplace England

MOTHER
14. Maiden Name Margaret Towers
15. Birthplace England

16 (a) Informant Mrs. Rose DeLane
(b) Address 2512 Hermosa Ave.

17 (a) Burial (b) Date thereof 2/14/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. Md.

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St.

19 (a) FEB 12 1948 (b)
(Date rec'd by registrar) Registrar
Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1948, at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 1948, to Feb 10 1948, and that I last saw him alive on Feb 10 1948.

Immediate cause of death	Duration
Carcinoma of left lung	1-1½ yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 2-9-48
Major findings of operation: Carcinoma of left lung
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Robert J Johnson M. D.
Address Mercy Hospital Date signed 2-10-48

X

G60074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G60074 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Lexington St.
(c) Hospital or institution:
Aged Females Aged Mens Homes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 N Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Murray Frazier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	widowed

6 (b) Name of husband or wife Rose Dowling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23. 1854

8. AGE: Years	Months	Days	If less than one day
93	8	19	hr. min.

9. Birthplace Chestertown Md
(Town, county, and state)
10. Usual Occupation Inmate
11. Industry or business Home for Aged

FATHER
12. Name Samuel Frazier
13. Birthplace

MOTHER
14. Maiden Name Emmeline Cleaver
15. Birthplace

16 (a) Informant P.N. Read
(b) Address 1400 N. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/48 (month) (day) (year)
(c) Cemetery or crematory
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1219 E Fayette St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1948 at 5 00 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1947 to Feb 10 1948 and that I last saw him alive on Feb 10 1948

Immediate cause of death Respiratory Failure, Cardiac Failure

Due to Hypostatic Pneumonia

Due to Arteriosclerotic Cardio-Vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maryland Edward Day M. D.
Address 4-E-33rd St Baltimore Date signed Feb 11 1948

V S 150

G60075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G60075

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2211 W Rogers

(c) Hospital or institution: Methodist Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yrs

(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltcity

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2211-W-Rogers Av (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country -

3 (a) FULL NAME Annie Lee Baumgardner

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4 Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Geo H. Baumgardner

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 6 1865

8. AGE: Years 82 | Months 10 | Days 4 | If less than one day: hr. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER

12. Name Carrington Gosnell

13. Birthplace Carroll Co. Md.

MOTHER

14. Maiden Name Elizabeth Ebaugh

15 Birthplace Carroll Co. Md.

16 (a) Informant Mrs Annie L. Baumgardner (Wife)

(b) Address 2211 W Rogers Av.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 12-48 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location Baltimore

18 (a) Funeral director STEWART & MOWEN COMPANY

(b) Address (W. F. MOWEN SUC.), 100 N. HOWER AVENUE Penitentiary for Williamsport, Md.

FEB 12 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-10 1948 at 3.6 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1948 to Feb 9 1948 and that I last saw h E M alive on Feb 9 1948.

Immediate cause of death	Duration
Myocardial Insufficiency	5 days
Due to	
Due to Diabetes	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Arthur J Davis M. D.

Address 800 W 33rd St Date signed 2-11-48

VS 150

93E

G60076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63 B

G60076

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1903 McCulloh
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1903 McCulloh
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Elizabeth Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband ~~or wife~~ Pleamentius

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 60 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Prince George Co, Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name working on Jackson

13. Birthplace Prince George Co, Md.

MOTHER — 14. Maiden Name Sarah Tillman Tillman

15. Birthplace Md

16. (a) Informant Pleamentius Johnson

(b) Address 1903 McCulloh St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-48 (month) (day) (year)

(c) Cemetery or crematory Carlton

Location Baltimore Md

18. (a) Funeral director Frances A. Hemsley

(b) Address 578 W. Baltimore st

19 FEB 12 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1948, at 12 noon A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948, to Feb 10 1948, and that I last saw her alive on Jan 9 1948.

Immediate cause of death Exophthalmic Goiter — Duration 1 yr

Due to Toxemia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Fisher M. D.
Address 1412 E Monument Date signed 11/ /48

G60077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G60077 ✓ Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Use "None" where necessary. If unknown, supply best information obtainable. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Sinai Hospital

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 ✓ 13

(e) Length of stay in Baltimore (yrs., ~~mos.~~ or ~~days~~) 25

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. Md. (If outside city or town limits, write RURAL and give town)

(d) Street No. 2821 Sante Fe Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Forman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married Edna Nee Kimmel

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 189 ✓

8. AGE: Years	Months	Days	If less than one day
56 55			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER 12. Name Isidore Forman

FATHER 13. Birthplace Russia

MOTHER 14. Maiden Name Sarah Silverstein

MOTHER 15. Birthplace Russia

16 (a) Informant Mrs Edna Forman

(b) Address 2821 Sante Fe Ave

17 (a) Burial (b) Date thereof Feb, 12, 1948 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Hebrew Young Men Cem

Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124-1126 W North Ave

19 (a) (b) Huntington Williams Md

FEB 12 1948

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1948, at 6.50 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 11 1948 to Feb 11 1948 and that I last saw h alive on Feb 11 1948.

Immediate cause of death	Duration
a Ext Fracture of skull	
b Extradural & subdural haemorrhage	
c Contusion	
Due to (a) left	
falling down stairs	
Due to	
Other Conditions Few fractured ribs	

(Include pregnancy within 3 months of death)

Date of operation Feb 11/48

Major findings of operation: Subdural haem on left

of autopsy: see above.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 15/13

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence Feb 11 at 3.00 P.M

(c) Where did injury occur? Baltimore Md (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No

(e) Means of injury Fell down steps, hit head on cement floor

23. Signature M. Liedenberg M. D.

Address Sinai Hospital Date signed Feb 12 1948

Howard J. Sunderland 2/9/48

G60078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G60078 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & Hahn Sts.
(c) Hospital or institution: Hospital for the Women of Md. 77
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 da
(e) Length of stay in Baltimore (yrs., mos., or days) unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4607 Keswick Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GRACE ELSIE BULL.

3 (b) If veteran, name war: unknown

3 (c) Social Security Account No. unknown

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of husband or wife George L. Bull
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Aug 17, 1886

8. AGE: Years	Months	Days	If less than one day
61	5	25	hr. min.

9. Birthplace Whitehall, Md. (Town, county, and state)
10. Usual Occupation H.W.
11. Industry or business

FATHER
12. Name George W. Phelps
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Jeanette Bowen
15. Birthplace Baltimore, Md.

16 (a) Informant Admission Blank, Hospital.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 13 1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Chenoweth & Hammond
(b) Address 2612-17 Chestnut Ave.

19 (a) FEB 12 1948 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1948, at 7:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1948, to Feb 11 1948, and that I last saw her alive on Feb 10 1948.

Immediate cause of death Cardiac Failure.

Due to Possible Coronary occlusion.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: none
of autopsy: none

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Woodlawn M. D.
Address Hospital for the Women of Md. Date signed 2-11-48

VS 150

G60079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

G60079 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 Field Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** ALICE V. GOBBEL

3 (b) If veteran, name war

3 (c) Social Security Account No. 248-09-7178

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Henry R. Gobbel

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Sept 25 1909

8. AGE: Years 38 | Months 4 | Days 16 | If less than one day ..... hr. ..... min.

9. Birthplace South Carolina. (Town, county, and state)

10. Usual Occupation Winder Tender.

11. Industry or business Textile Mill.

FATHER
12. Name Jesse L. McLendon
13. Birthplace S. C.

MOTHER
14. Maiden Name Florence Kelley.
15. Birthplace S. C.

16 (a) Informant Henry R. Gobbel.
(b) Address 711 Field St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 14/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Park
Location

18 (a) Funeral director Shenamuth & Donavan
(b) Address 3615-17 Reisterstown Ave.

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/11/48 19..., at 3:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carbon monoxide poisoning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2/11/48 at 1:00 P.M.
(b) Where did injury occur? 711 Field Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Turned on gas burners unlit

23. Signature John R. Wade M.D. Medical Examiner
Date signed 2/11/48

VS 151

660080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

660080 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 505 Poplar Grove, St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Dorchester
(c) City or town Cambridge, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen Elizabeth Everhart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John D. Everhart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jany 6, 1865

8. AGE: Years	Months	Days	If less than one day
83	1	5	hr. min.

9. Birthplace Cambridge, Md
(Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name James Brannock
13. Birthplace Cambridge, Md

MOTHER
14. Maiden Name Elizabeth Dail
15. Birthplace Cambridge, Md

16 (a) Informant Mr George Everhart
(b) Address 505 Poplar Grove, St

17 (a) Burial (b) Date thereof Feb. 14, 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenlawn
Location Cambridge, Md

18 (a) Funeral director le Compte Funeral Service
(b) Address Cambridge, Md.

19 (a) Date received by registrar FEB 18 1948 (b) Registrar Remington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1948, at 8 A. M

21. I certify that death occurred on the date above-stated; that I attended deceased from Aug 1 1947, to Feb 11 1948, and that I last saw h alive on Feb 10 1948.

Immediate cause of death Hypertrophy of cardiac insufficiency & degeneration of pulmonary valves
Due to Chronic arteriosclerotic type heart disease with hypertrophy & congestive failure
Due to Generalized arteriosclerosis with hypertension
Other Conditions

Duration: 4 months, Several years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. O. Michel M. D.
Address 2901 Edmondson, Ave Date signed

X

G60081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G60081 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2321 Aiken St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give name)
(d) Street No. 2321 Aiken St.
(if rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie V. Drury.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Mulatto | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Richard A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17-1858

8. AGE: Years 89 | Months 5 | Days 24 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Geo. W. Beard.

13. Birthplace Balto Co. Md.

MOTHER 14. Maiden Name Abbie Jermilje

15. Birthplace Balto. Co. Md.

16 (a) Informant Guy E. Hartley

(b) Address 2321 Aiken St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/48 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Taylor Ave. Md.

18 (a) Funeral director Albert J. Valentine

(b) Address 2326 Aiken St.

(c) Date received by registrar FEB 12 1948 (b) Registrar's signature Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/10/48, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943, to Feb. 10 1948, and that I last saw h[illegible] alive on Feb. 2 1948.

Immediate cause of death	Duration
Dehydration	2 mos.
Due to General senile changes	—
Due to Arteriosclerosis	—
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bert B. Wright M.D. M. D.

Address Medical Arts Bldg. Date signed 2/12/48

VS 150

X

G60082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G60082

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves
(c) Hospital or institution St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 da
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 502 Resolution Pl.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK J. KLEIN.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	White	married

6 (b) Name of husband or wife Marie Voth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-10-1890.

8. AGE: Years	Months	Days	If less than one day
57.	5	-	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Nicholas Klein
13. Birthplace Germany

MOTHER
14. Maiden Name Madalene
15. Birthplace Germany

16 (a) Informant George R. Klein
(b) Address 502 Resolution St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair & Rd.

18 (a) Funeral director Selby & Zeibach
(b) Address 1923 W. Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 12 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/10/1948, at 3:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1/1948 to 2/10/1948 and that I last saw h alive on 2/10/1948.

Immediate cause of death	Duration
Cardiac failure - Coronary sclerosis - Arteriosclerotic Heart Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address [illegible] Date signed 2/10/48

Medicare ✓ 660083 450747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

660083 Registered No. 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Broadway & Monument St
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days): 7
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 205 S. Clinton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country:

3 (a) FULL NAME: Charles Franklin

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr): 10-8-71

8. AGE: Years: 76 | Months: 4 | Days: 2 | If less than one day: hr. min.

9. Birthplace: Va (Town, county, and state)

10. Usual Occupation:

11. Industry or business:

FATHER — 12. Name: Robert Franklin
13. Birthplace: Va

MOTHER — 14. Maiden Name: Elizabeth Mays
15. Birthplace: Va

16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-48 (month) (day) (year)
(c) Cemetery or crematory: Fork Christian
Location: Fork, Md.

18 (a) Funeral director: Tilley & Zeiler Inc.
(b) Address: 403 S. Wolfe St. 31

19 (a) (Date received by registrar) (b) Registrar's signature

FEB 9 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 10, 1948, at 9:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 1948 to Feb 10 1948, and that I last saw h[illegible] alive on Feb 10 1948.

Immediate cause of death: Unknown. Probable embolism — Duration:

Due to: Fracture intertrochanteric right femur. — 3 days.

Due to: Accident 6 Feb. 48. fall.

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: 9 Feb 48

Major findings of operation: fracture neck of femur rt.

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 3/1

(a) Accident, suicide, or homicide: fall.
(b) Date of occurrence: 6 Feb 48 at 3:15 P M
(c) Where did injury occur? [illegible] Baltimore, Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public (Specify type of place) While at work? No
(e) Means of injury: Fell on floor down police station

23. Signature: R.S. Mossman M. D.

Address: [illegible] Date signed: 2/10/48

Form 150

Howard J. Mossman M.D.

G60084

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. G60084

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): less than 2 days
(e) Length of stay in Baltimore (yrs., mos., or days): 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 1637 N. Bradford St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Milton Ralph Scott

3 (b) If veteran, name war: WWI & WW 2
3 (c) Social Security Account No.: - - -

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Frohn Scott
6 (c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): October 10, 1888

8. AGE: Years: 59 | Months: 4 | Days: 0 | If less than one day: hr. min.

9. Birthplace: Pettin Co. Mo.
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business:

FATHER
12. Name: Milton David Scott
13. Birthplace: Mo.

MOTHER
14. Maiden Name: Rovella Seed
15. Birthplace: Mo.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2/14/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore National
Location: Frederick Avenue

18 (a) Funeral director: M. F. Sadowski & Sons
(b) Address: 1808 Eastern Aveme

19 (a) (Date received by Registrar) FEB 17 1948 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 10 1948, at 2:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 8 1948 to Feb. 10 1948, and that I last saw h im alive on Feb. 10 1948.

	Duration
Immediate cause of death: Cerebral hemorrhage	3 days
Due to:	
Due to:	
Other Conditions: Diabetes mellitus (Include pregnancy within 3 months of death)	2 yrs.
Date of operation:	
Major findings of operation:	
of autopsy: Not done	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed: 2/10/48

83a

G60085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

G60085 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State U.S.A. (b) County

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Lottie Tibuski Coughlin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John Coughlin

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 26

8. AGE: Years 40 | Months 8 | Days 15 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Joseph Tibuski

13. Birthplace Poland

MOTHER 14. Maiden Name Zofia —

15. Birthplace Poland

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/48 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Mt. Carmel Road

18 (a) Funeral director M. J. Radonsky & Sons

(b) Address 1808 Eastern Ave

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 , at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death Acute hepatic failure — Duration 2 weeks

Due to Cirrhosis of Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature David Grob, M.D.

Address J. H. H. Date signed 1/28/48

VS 150

Tentative Notification

G60086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

G60086

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 days

2. USUAL RESIDENCE OF DECEASED:
(a) State DC (b) County
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4310 Windham Place, NW
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME
Richard Martin Morrill

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
--	--	M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1928

8. AGE: Years	Months	Days	If less than one day
19	6	28	hr. min.

9. Birthplace: Winchester, Mass.
(Town, county, and state)
10. Usual Occupation: Student
11. Industry or business

FATHER
12. Name: Arthur Morrill
13. Birthplace: Boston, Mass.

MOTHER
14. Maiden Name: Kathleen Sheehan
15 Birthplace: Mass.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 12-1948 (month) (day) (year)
(c) Cemetery or crematory
Location: Boston Mass

18 (a) Funeral director: Pratt Co B.M. Walker
(b) Address: Pratt & Charles Sts

19 (a) FEB 12 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11 1948, at 6:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 7 1948, to Feb. 11 1948, and that I last saw him alive on Feb. 11 1948.

Immediate cause of death	Duration
Lymphosarcoma	
with involvement of liver,	5 yrs.
spleen, lymph nodes, peri-	
Due to toneum, kidneys	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 2/12/48

VS 199

660087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

660087
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy 17-W
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 620 West Lanvale
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Hayes Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife Rachel Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March, 1896

8. AGE: Years	Months	Days	If less than one day
51	11		hr. min.

9. Birthplace Penna.
(Town, county, and state)

10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name James Williams.
13. Birthplace Penna.

MOTHER
14. Maiden Name Annie
15. Birthplace Penna.

16 (a) Informant Rachel Williams.
(b) Address 620 W. Lanvale St.

17 (a) Burial (b) Date thereof Feb. 12, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

FEB 12 1948 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9/48, 19, at 5:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 2/10/48

X

G60088

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

180

G60088

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17-1
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 655 W. Franklin Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES MILLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1905

8. AGE: Years 42 | Months 7 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Sumter S.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Napoleon Miller.
13. Birthplace Sumter, S.C.

MOTHER
14. Maiden Name Anna Brockington.
15. Birthplace Manning S.C.

16 (a) Informant Charles Gibbs.
(b) Address 1716 Freestman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 12, 1948. (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) 2-12-1948 (Date rec'd by registrar) Transferred from Williams, Md. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7, 1948, at 6.20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to 2nd - 3rd° Burns

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 17/3

(a) Date of injury 1-28-48 at 11.30 p.m.
(b) Where did injury occur? 504 Ogston St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury House afire.

23. Signature [signature] M.D. Medical Examiner
Date signed 2-7-48

X

660089

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95c

Registered No. 660089

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 22 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County
(c) City or town Colorado City (If outside city or town limits, write RURAL and give town)
(d) Street No. 129 E. 7th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ova Huff
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Bernice
6 (c) If alive, give age 40 years
7. Birth date of deceased (mo., day, yr.) 4-14-04
8. AGE: Years 43 | Months 9 | Days 26 | If less than one day hr. min.
9. Birthplace Texas (Town, county, and state)
10. Usual Occupation FOREMAN
11. Industry or business RANCHING

FATHER: 12. Name Augustus Huff; 13. Birthplace Texas
MOTHER: 14. Maiden Name Cora Dickerson; 15. Birthplace Texas

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Feb. 16, 1948 (month) (day) (year)
(c) Cemetery or crematory
Location Colorado City Texas
18 (a) Funeral director Walter Brooks Bradley
(b) Address 1922 W. North avenue
19 (a) (Date rec'd by registrar) (b) Huntington Willis Registrar

FEB 12 1948

VS-100

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1948, at 12:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1948 to Feb 10 1948, and that I last saw h. alive on Feb 10 1948.

Immediate cause of death: Operation: Third ventriculostomy
Due to: Stricture of Aqueduct of Sylvius
Due to:
Other Conditions: Gangrene Lung Pneumonia
(Include pregnancy within 3 months of death)
Date of operation Feb 3 '48
Major findings of operation: Voiceage
of autopsy: As above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George L Culbreth
Address John Hopkins Hosp Date signed 2-26 1948

X

G60090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G60090

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be accurately supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 18-✓
(b) Street address
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1103 Boone Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John BARCLAY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER
12. Name John W. Barkley
13. Birthplace md

MOTHER
14. Maiden Name Fannie ~ ?
15. Birthplace md

16 (a) Informant Katie Satchell
(b) Address 1103 Boone Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/48 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location

18 (a) Funeral director Elroy Coleman
(b) Address 1000 Braddish Lane

19 (a) FEB 12 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1948, at 11:20 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 2/7/48

VS 181

G60091 ✓ G60091

GM. 117345 117345

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals. 18-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 849 W. Lombard ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Daisy Gibson ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Late George W. Gibson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21 - 1881

8. AGE: Years	Months	Days	If less than one day
66	1	21	hr. min.

9. Birthplace MD. (Town, county, and state)
10. Usual Occupation House Work
11. Industry or business at Home

FATHER
12. Name Dewey Elison
13. Birthplace MD.

MOTHER
14. Maiden Name Daisy ?
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/48 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location 2933 Frederick Ave

18 (a) Funeral director John J. Gannon & Son
(b) Address 901-03 Hollins St

19 (a) 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 11 - 1948, at 920 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 - 10 - 1948, to 2 - 11 - 1948, and that I last saw her alive on 2 - 11 - 1948.

Immediate cause of death	Duration
Pneumonia	4 days
Due to	
Due to	
Other Conditions Arteriosclerotic Heart Disease & Failure (Include pregnancy within 3 months of death)	5

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. R. Feigenbaum M.D.
Address Balto. City Hosp Date signed 2-13-48

X

G60092

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G60092 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1217 Washington Blvd
(c) Hospital or institution: 2-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 Washington Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Pauline L. Mangold

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife William J. H. Mangold
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8th 1887

8. AGE: Years	Months	Days	If less than one day
60	7	4	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation House Work
11. Industry or business at Home

FATHER
12. Name Frederick Dressel
13. Birthplace Germany

MOTHER
14. Maiden Name Jennie Beckmann
15. Birthplace Baltimore Md.

16 (a) Informant Mr. William J. H. Mangold
(b) Address 1217 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 16 48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location 3801 Frederick Ave

18 (a) Funeral director John J. Gowan & Son
(b) Address 901-03 Hollins St.

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12th 1948, at 1 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1945 to Feb 12 1948; and that I last saw h[illegible] alive on Feb 4 1948

Immediate cause of death Coronary Occlusion — Duration 1 day
Due to Coronary Artery Disease — Duration 4 months
Due to — Duration
Other Conditions — Duration
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John P. Walsh M.D.
Address 1227 Wash Blvd Date signed 2/14/48

X

660093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660093

GM. 111367

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Months
(e) Length of stay in Baltimore (yrs., mos., or days) 17 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Somerset
(c) City or town Chrisfield (If outside city or town limits, write RURAL and give town)
(d) Street No. Chrisfield, MD, Box 248 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Dobson Or James A. Dodson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Carolyn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27 -1906

8. AGE: Years	Months	Days	If less than one day
41	4	4	hr. min.

9. Birthplace VA. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Dobson Or John Dodson
13. Birthplace VA.

MOTHER
14. Maiden Name Mary Jane Dobson Or Dodson
15. Birthplace VA.

16 (a) Informant Records Balto. Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-48 (month) (day) (year)
(c) Cemetery or crematory Bunny Ridge
Location Cropsville, Md

18 (a) Funeral director N. Harvey Bradshaw
(b) Address Cropsville, Md

FEB 13 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 1 - 1948, at 1.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 - 12 - 1948, to 2 - 1 - 48, and that I last saw h imalive on Feb. 1 - 1948.

	Duration
Immediate cause of death Bronchial pneumonia	5 days
Due to Tuberculous Emphysema	4 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2-7-47
Major findings of operation: Lung abscess
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. E. George M. D.
Address 4940 Eastern Ave. Date signed 2-11-48

VS 150

J. E. George

660094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 660094

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4506 Sorrento Avenue

(c) Hospital or institution: Colonial Nursing Home 21-V

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 59 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1270 Sargent Street (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Otto Müller

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Emma Müller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23-1864

8. AGE: Years 83 | Months 8 | Days 16 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired Steel Worker

11. Industry or business

FATHER

12. Name Müller

13. Birthplace Germany

MOTHER

14. Maiden Name Unknown

15. Birthplace Germany

16 (a) Informant Charles J. Miller

(b) Address 1837 Ramsay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-48 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location A. A. County

18 (a) Funeral director George E. J. Schwab

(b) Address 2101 Fredrick Ave

19 (a) FEB 13 1948 (Date rec'd by registrar) (b) [illegible] (Date filed)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10 1948, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 18 Jan 1948, to 10 Feb 1948, and that I last saw him alive on 10 Feb 1948.

Immediate cause of death	Duration
Bronchopneumonia	3 days
Due to	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible]

Address 142 Wartman Rd Date signed 2-11-48

VS 150

107

G60095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G60095

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13-1
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Rochester Court Apts. D.2. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Morris N. Schlaen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Minnie Schlaen

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) 1-16-88 1881

8. AGE: Years	Months	Days	If less than one day
67	-	28	hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Druggist

11. Industry or business

FATHER 12. Name Mendel Schlaen

13. Birthplace Russia

MOTHER 14. Maiden Name Pearl Z.

15. Birthplace Russia

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/48 (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship

Location E. Baltimore St

18 (a) Funeral director Sol Levering Bro

(b) Address 1124-26 W Northern

19 (a) FEB 13 1948 (Date rec'd by registrar) (b) Washington Hill

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13 1948, at 12:39 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9 1948 to Feb 13 1948 and that I last saw him alive on Feb 13 1948

Immediate cause of death Hypertensive cerebro-pathy and uremia — Duration 4 yrs.

Due to Hypertensive cardio-vascular disease

Due to

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.

Address [illegible] Date signed 2-13-48

VS 150

60096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 60096

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 504 S Potomac St

(c) Hospital or institution: 1-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 504 S Potomac St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Jadwiga Polek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife John J. Polek

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14 / 92

8. AGE: Years	Months	Days	If less than one day
55 56	10	27	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER

12. Name Adam Zadlo

13. Birthplace Poland

MOTHER

14. Maiden Name Ewa Slawik

15. Birthplace Poland

16 (a) Informant John J. Polek

(b) Address 504 S Potomac St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 14/48 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Baltimore

18 (a) Funeral director Fred W Ograzewski

(b) Address 1930 Eastern Ave

19 FEB 13 1948 (Date rec'd by registrar) Washington Village

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10 1948, at 8:10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948 to Feb 1948, and that I last saw her alive on Feb 9 1948

Immediate cause of death	Duration
Myocardial failure	1 wk
Due to Adenocarcinoma right breast with extensive metastasis	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Clarence W. LeGoux M. D.

Address 631 S Ellwood ave Date signed 2/13/48

V S 150

G60097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G60097

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ✓
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: The Seton Institute 28-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6420 Reisterstown Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Sister Louise Mullane

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife
6 (c) If alive, give age 11/21/1899 years

7. Birth date of deceased (mo., day, yr.) 48 yrs., 3 mo., 15 days

8. AGE: Years 48 | Months 3 | Days 15 | If less than one day hr. min.

9. Birthplace Syracuse, New York (Town, county, and state)
10. Usual Occupation Daughter of Charity
11. Industry or business

MOTHER | FATHER
12. Name William Mullane
13. Birthplace Warneis, New York
14. Maiden Name Mary Burns Mullane
15. Birthplace Wexford Co., Ireland

16 (a) Informant The Seton Institute
(b) Address 6420 Reisterstown Rd., Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-48 (month) (day) (year)
(c) Cemetery or crematory Prov.-Seton Inst.
Location 6420 Reisterstown Rd.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. MOWEN SEC.) 100 W. SOUTH AVENUE Huntington for Williamsport, Md.

19 (a) FEB 13 1948 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 11 1948, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from December 1946, to Feb. 11 1948, and that I last saw her alive on Feb. 11 1948

Immediate cause of death Carcinoma Mitosis — Duration 3 years
Due to
Due to
Other Conditions Carcinoma of left breast (Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 23 W. Fayette St. Date signed

VS 180

X

C60098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C60098

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3218 Elliott St.
(c) Hospital or institution: Home 26-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3218 Elliott St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael J. Nowicki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Cecilia Nowicki

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15 1896

8. AGE: Years 51 | Months 6 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Grocery business

FATHER
12. Name John J. Nowicki
13. Birthplace Poland

MOTHER
14. Maiden Name Wladyslawa Janoska
15. Birthplace Poland

16 (a) Informant Cecilia Nowicki
(b) Address 3218 Elliott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/48 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Ave

18 (a) Funeral director John J. Duda
(b) Address 2849 Hudson St.

19 (a) Filed FEB 13 1948 (Date rec'd by Reg. or Dep. Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 12 1948, at 8.05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from NOV. 1947 to 12 FEB. 1948, and that I last saw h.i. alive on 11 FEB. 1948.

Immediate cause of death CORONARY THROMBOSIS — Duration 1 hr.
Due to HYPERTENSIVE HEART DISEASE — 10 yrs.
Due to ARTERIOSCLEROSIS, GEN. — 10 yrs.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide at M
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Hyhraten M. D.
Address 121 S. HIGHLAND AVE. Date signed Feb. 12 1948

VS 150

660099 BC-F #3126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660099

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1634-N. Gilmor St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Brenda FOUNTAIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 19-1942

8. AGE: Years: 6 | Months: - | Days: 22 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name James Fountain

13. Birthplace Wash. D.C.

MOTHER 14. Maiden Name Cornelia Holmes

15. Birthplace Virginia

16 (a) Informant Cordelia Fountain (mother)

(b) Address 1634 N. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 14 48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location West Port Via Brooks

18 (a) Funeral director

(b) Address 1463 N. Carey St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10, 1948, at 2:30 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Suffocation by inhalation of smoke

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 15/1

(a) Date of injury 2/10/48 at 1634-N. Gilmor St M.

(b) Where did injury occur? Patterson Park

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury House afire

23. Signature George L. Merrill M.D. Medical Examiner.

Date signed 2/10/48

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

660100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 660100

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1720 ASHBURTON ST.
(c) Hospital or institution: 5.6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1720 ASHBURTON ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME JESSE ARCHIBALD McGEE

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife: IDA MAY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1870

8. AGE: Years	Months	Days	If less than one day
77	3	9 10	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation
11. Industry or business OPERATOR - BT COMPANY

FATHER
12. Name AQUILLA McGEE
13. Birthplace CARROLL CO., MD.

MOTHER
14. Maiden Name ANNA LOCKARD
15. Birthplace CARROLL CO., MD.

16 (a) Informant WIFE
(b) Address 1720 ASHBURTON ST.

17 (a) BURIAL (b) Date thereof 2/13/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory BETHEL CHURCH of GOD
Location CARROLL CO. MD.

18 (a) Funeral director WM J. TICKNER & SONS INC
(b) Address BALTO, MD.

19 (a) FEB 13 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/10/48, 19, at 3:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19 45 to Feb 10 19 48
and that I last saw him alive on 2. 10 19 48.

Immediate cause of death	Duration
(a) Hypertensive heart disease	Hypd.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Krueger, M. D.
Address 1402 E. Fayette Date signed 2-12-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

0101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 108

Registered No. 60101

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2028 Druid Hill
(c) Hospital or institution: 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2028 Druid Hill
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Th. Alston.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C.	Widower

6 (b) Name of husband or wife Mary Alston.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1 1886

8. AGE: Years	Months	Days	If less than one day
61	7	10	hr. min.

9. Birthplace Littleton, N.C.
(Town, county, and state)
10. Usual Occupation Laborer.
11. Industry or business

FATHER
12. Name William Alston.
13. Birthplace Littleton N.C.

MOTHER
14. Maiden Name Fannie Alston.
15. Birthplace Littleton N.C.

16 (a) Informant George Randolph.
(b) Address 2028 Druid Hill Ave.

17 (a) Burial (b) Date thereof 2-6-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Haywood Co.
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N. Schroeder St

19 (a) 2-3 1948 (b) Huntington-Williams
(Date received by registrar) (Signature of funeral director)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 : 11 : 1948 at 5:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 : 4 1948 to 2 : 11 : 1948, and that I last saw h— alive on 2 : 11 : 1948.

Immediate cause of death	Duration
Acute Myocardial	1 D
Due to Coronary Insufficiency	5 D
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. L. Peery M. D.
Address 1420 E. Chase Date signed 2 : 13 : 48

X

060102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. 060102

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Forest Hills (If outside city or town limits, write RURAL and give town)
(d) Street No. 6910 Yellowstone Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Sloane

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Rachel
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) 3-30-(08)1910

8. AGE: Years	Months	Days	If less than one day
37 (39)	10	16	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Harry Stepovitz
13. Birthplace Poland

MOTHER
14. Maiden Name Sara Huber
15. Birthplace Poland.

16 (a) Informant Friend
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-15-48 (month) (day) (year)
(c) Cemetery or Crematory Location New York, N.Y.

18 (a) Funeral director Hebrew Relief Soc.
(b) Address 116 Eastern Pkwy

19 (a) FEB 13 1948 (Date rec'd by Registrar) (b) Thurlington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13 1948 at 4:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8 1947 to Feb. 13 1948, and that I last saw him alive on Feb. 13 1948.

Immediate cause of death Peritonitis — Duration 18 mo
Due to Carcinoma of sigmoid
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Adhesions
of autopsy: (New York City)

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 2-13-48

VS 150

G60103

BC : 630714

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

G60103 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13-4
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Towson Falls Pkway. (If no street location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Stephen Hirschhorn

3 (b) If veteran, name war No | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1945

8. **AGE:** Years 2½ yrs. | Months | Days | If less than one day hr. min.

9. Birthplace Balt. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name J. Leonard Hirschhorn
13. Birthplace Md

MOTHER
14. Maiden Name Kendler
15. Birthplace Md.

16 (a) Informant Leonard Hirschhorn
(b) Address 1616 Towson Falls Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location Jack Lewis Inc

18 (a) Funeral director
(b) Address 210 Eastern Ave

19 FEB 13 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. **DATE OF DEATH** Feb. 13 1948, at 1:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1948, to Feb. 13 1948, and that I last saw h[illegible] alive on Feb. 12 1948.

Duration

Immediate cause of death Respiratory Failure

Due to Diffuse Broncho-pneumonia

Due to

Other Conditions Post encephalitic petit mal Epilepsy
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: bilateral congestion of lungs prob bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert C. Huntley M.D. M. D.
Address University Hosp. Date signed 2-13-48

660104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 660104

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 41 So Pulaski St
(c) Hospital or institution: 20-3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 41 So Pulaski St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Lehem

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Sarah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1877

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Samuel
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie
15. Birthplace Russia

16 (a) Informant Sarah Lehem
(b) Address 41 So Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-48 (month) (day) (year)
(c) Cemetery or crematory
Location Netherwood Friendship
18 (a) Funeral director Jack Lewis Dec
(b) Address 2 So Eutaw Place

19 (a) FEB 13 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-13-1948, at 4:47 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1948 to Feb 13 1948, and that I last saw h[illegible] alive on Feb 13 1948

Immediate cause of death	Duration
Acute pulmonary edema	
Due to Coronary thrombosis acute.	
Due to Arteriosclerosis	
Other Conditions History of diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. E. Randle, M.D.
Address 2314 Dn North Ave Date signed 2/13/48

VS 150

94a

60105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

Registered No. 60105

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 27-17 Greenspring Ave
(c) Hospital or institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jennie Tucker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Israel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 83 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Moses

13. Birthplace Russia

MOTHER 14. Maiden Name Not Known

15. Birthplace Russia

16 (a) Informant Elmer Hackerman

(b) Address 2472 Keyworth Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-48 (month) (day) (year)

(c) Cemetery or crematory Adas Israel

Location Reisterstown Rd

18 (a) Funeral director Jack Levin Inc

(b) Address 210 Eutaw Place

19 (a) FEB 13 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12th 1948, at 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15th 1948, to Feb. 12th 1948, and that I last saw her alive on Feb. 11th 1948.

	Duration
Immediate cause of death: Cerebral thrombosis	
Due to: Arteriosclerosis & Senility	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome J. Blumberg M. D.

Address Levindale Home Date signed 2/12/48

VS 150

660106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

660106

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Calvert
(c) City or town Broomes Island
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET MAY BUCKMASTER

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	MARRIED

6 (b) Name of husband or wife Herbert A. Buckmaster
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1923

8. AGE: Years	Months	Days	If less than one day
24	9	2	hr. min.

9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name John T. Daugherty
13. Birthplace Md.

MOTHER
14. Maiden Name Cora Newschaffer
15. Birthplace Md.

16 (a) Informant Herbert Buckmaster
(b) Address 3920 Old Frederick Rd Cty (or town)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons Inc.
(b) Address Balto, Md.

19 FEB 19 1948 (b) Registrar
(Date filed by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-12 1948, at 12 15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-29 1948 to 2-12 1948 and that I last saw h[illegible] alive on 2-12 1948

Immediate cause of death
Diffuse, active Bronchogenic Tuberculosis — Duration 15 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James A. C. Finney M. D.
Address Union Memorial Hosp Date signed 2-12-48

G60107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G60107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4006 Penhurst Ave
(c) Hospital or institution: 15-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4006 Penhurst Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: William Colladay Burgess

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Carolina B. Burgess
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 6 1865

8. AGE: Years	Months	Days	If less than one day
83		6	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Insurance
11. Industry or business Riggs?Warfield & Roloson

FATHER
12. Name Charles R. Burgess
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Ellen Colladay
15. Birthplace Baltimore Md

16 (a) Informant Carolina B. Burgess
(b) Address 4006 Penhurst Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 14 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Harry M. Armacost
(b) Address 4204 Ridgewood Ave

19 (a) 2 13 1948 (Date rec'd by Registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12 1948, at 4.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1944 to Feb. 12 1948 and that I last saw him alive on Feb. 11 1948.

Immediate cause of death
1) - Arteriosclerosis
Cardio-Vascular Disease

Duration
- 5 yrs ?

Due to

Due to

Other Conditions - Cerebral Hemorrhage -
(Include pregnancy within 3 months of death)

1 yr.

Date of operation - None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature - Earl L. Chambers M.D.
Address 4106 Liberty Hts. Date signed 2/14/48

VS 150

X

C60108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

Registered No. C60108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Bon Secours
(b) Street address West Fayette St.
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) From 2/10/48 to 2/11/48
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town RURAL - Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. 5242 Wasena Avenue - Zone 2 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Lloyd (Margaret Ann Lloyd)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	

6 (b) Name of husband or wife Gordon W. Lloyd
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) 2/5/48

8. AGE: Years	Months	Days	If less than one day
		7 6	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Nicholas Lloyd
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Bloom
15. Birthplace Maryland

16 (a) Informant Gordon W. Lloyd
(b) Address 5242 Wasena Ave., Brooklyn, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 14 1948 (month) (day) (year)
(c) Cemetery or crematory Finksburg Methodist Church Cemetery
Location Finksburg

18 (a) Funeral director George A. Nusbaum
(b) Address Reisterstown, Md.

FEB 13 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1948, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1948, to Feb 11 1948 and that I last saw h[illegible] alive on Feb 11 1948.

Immediate cause of death Respiratory failure
Due to pneumonia, lobular, bilateral
Due to stomach
Other Conditions pneumothorax, spontaneous, right
(Include pregnancy within 3 months of death)

Duration

Date of operation Feb 11 48
Major findings of operation: Lg. air bleb on lung surface
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. F. Lowe, M.D. M. D.
Address Bon Secours Hosp Date signed 2-11-48

VS 180

660109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 660109

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 613 S. Wolfe Street
(c) Hospital or institution: 2-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 51 Year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 613 S. Wolfe Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Bujewski (Boyer)

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-4565

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sep. 10 1886

8. AGE: Years	Months	Days	If less than one day
61	5	-	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name Michael Bujewski
13. Birthplace Poland

MOTHER
14. Maiden Name Josephine Kurek
15. Birthplace Poland

16 (a) Informant Harry Bujewski (Boyer)
(b) Address 613 S. Wolfe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 - 14 - 48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester street

FEB 13 1948 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION 12 45

20. DATE OF DEATH Feb 10 1948, at PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1947 to Feb 10 1948. and that I last saw h[illegible] alive on Feb 9 1948.

Immediate cause of death	Duration
Acute Cardiac Dilatation	2 days
Due to Coronary Asthma	2 yrs.
Due to Chronic Myocarditis	5 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John V. Kaczenski M. D.
Address 1802 Eastern Ave. Date signed 2-11-48

VS 150

660110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660110

BC-48-03099 20-1 161a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun St
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1912 W. Mulberry St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Medary Melvina Torance

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2/18/48

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace Baltimore — Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Melvin Torance
13. Birthplace N.C.

MOTHER
14. Maiden Name Florence Miller
15. Birthplace Balto. Md.

16 (a) Informant Wm. Melvin Torance
(b) Address 1912 W Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2.18.48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Rd

18 (a) Funeral director Harold Wilke
(b) Address 4101 Edmondson Ave.

19 (a) FEB 18 1948 (Date rec'd by Registrar) (b) [illegible] Registrar

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 Feb 1948, at 12:28 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9 Feb 1948 to 12 Feb 1948, and that I last saw her alive on 11 Feb 1948.

Immediate cause of death a. Telecyasis. — Duration —

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Geo Leonard M. D.
Address Franklin Sq Hosp. Date signed

X

60111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 B

Registered No. 60111

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2-1
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1132 Wash Blvd 2 Ft
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie Rookard

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-13-47

8. AGE: Years	Months	Days	If less than one day
53	4	26	hr. min.

9. Birthplace (Town, county, and state) SC

10. Usual Occupation
11. Industry or business

FATHER	12. Name Allan Foggie
	13. Birthplace [illegible] SC
MOTHER	14. Maiden Name Mary Cunningham
	15. Birthplace SC

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.A. Co Md

18 (a) Funeral director Isaac S Rinaldi & Son
(b) Address 08 N Montgomery St

19 (a) FEB 9 1948 (Date received by registrar) Walter for Williams M.D. (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-9-48, at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-7 19 48, to 2-9-19 48, and that I last saw h alive on 2-9 19 48.

Immediate cause of death Resp. failure — Duration

Due to Pneumonia

Due to HC v D

Other Conditions Chr. nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at P.M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Rinaldi M.D.
Address 9 W Mt Rd Date signed 2-11-48

92D 1T

060112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. 060112

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23 N. Vincent St.
(c) Hospital or institution: 19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 23 N. Vincen St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Amer. Citizen

3 (a) FULL NAME Samuel C. Bishop

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-5237

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	NEGRO	M

6 (b) Name of husband or wife Ella Bishop
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1894

8. AGE: Years	Months	Days	If less than one day
53	2	10	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation
11. Industry or business Mac Lea Lumber Co

FATHER
12. Name Abraham Bishop
13. Birthplace Cambridge Maryland

MOTHER
14. Maiden Name Margaret Oakley
15. Birthplace Baltimore Maryland

16 (a) Informant Ella Bishop
(b) Address 2391 Vincent Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof February 16 1948 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Cemetery
Location Baltimore City.

18 (a) Funeral director Joseph A. Lively
(b) Address 6 West Lane Ave

19 FEB 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11 1948, at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertrophy & acute dilitation of Heart

Due to

Other Conditions Acute pulmonary edema.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 2-12-48

VS 151

660113 WILBUR

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 660113

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 702 Warner Street

(c) Hospital or institution: 27-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 702 Warner Street (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Wilbur Saunders

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-9839

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1908

8. AGE: Years	Months	Days	If less than one day
39	9	1	hr. min.

9. Birthplace Reedville Va (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name John Henry Dowling

13. Birthplace Reedville Va

MOTHER

14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Blanch Pinebery

(b) Address 702 Warner Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof February 16, 1948 (month) (day) (year)

(c) Cemetery or crematory Mount Auburn Cemetery

Location Baltimore City

18 (a) Funeral director Joseph A. Boyle

(b) Address 6 West Lane Street

19 (a) (Date rec'd by registrar) (b) Signature of Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11 1948 at 8.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 13 1948 to Feb 11 1948, and that I last saw him alive on Feb 6 1948.

Immediate cause of death Bronchopneumonia — Duration 33 days

Due to Possibly T. B. C. Patient to send sputum

Due to ad to be X-rayed when being treated.

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John W. Gaines M. D.

Address 507 W. Hamburg St Date signed 2/12

VS 150

G60114

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G60114 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 722
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 649 West Lee Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, (widowed), or divorced.
Female	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 28, 188

8. AGE: Years	Months	Days	If less than one day
65	1	13	hr. min.

9. Birthplace Charles city Va (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER	12. Name Unknown
	13. Birthplace Unknown
MOTHER	14. Maiden Name Unknown
	15. Birthplace Unknown

16 (a) Informant Edward Walker
(b) Address 703 Warner St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof February 3, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore city

18 (a) Funeral director Joseph E Seay
(b) Address 661 Mt Auburn St

19 (Date rec'd by registrar) FEB 13 1948 Courtenay Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10, 1948, at 6 30 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl C Royer M.D. Medical Examiner
Date signed 2-11-48

VS 191

G60115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 184

Registered No. G60115

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11-3
(c) Hospital or institution: Don Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 845 N. Autaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MANUAL CARVAJAL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret Herman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15, 1901

8. AGE: Years	Months	Days	If less than one day
46	4	26	hr. min.

9. Birthplace San Juan, Puerto Rico (Town, county, and state)
10. Usual Occupation Barber
11. Industry or business

FATHER
12. Name Manuel Carvajal
13. Birthplace Puerto Rico

MOTHER
14. Maiden Name Ballina
15. Birthplace Puerto Rico

16 (a) Informant Mrs. Margaret Carvajal
(b) Address 845 N. Eutaw St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 14. 1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Ruth Wiedefeld
(b) Address 900 E. Biddle St

FEB 13 1948 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11, 1948, at 5:40 a.m. P.M.

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ (Probable), suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wound of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 11/3
(a) Date of injury 2-11-48 at 4:30 a.m. P.M.
(b) Where did injury occur? 845 N. Eutaw Place, Baltimore, Maryland
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature Earl Royer M.D.
Medical Examiner.
Date signed 2-11-48

X

G60116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G60116

121a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 431 Central Ave

(c) Hospital or institution: 5-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 431 Central Ave (If rural give location)

(e) Citizen of foreign country? N (Yes or No) If yes, name country

3 (a) **FULL NAME** Rosie Morris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	Col.	Married

6 (b) Name of husband or wife Milbourne

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1895

8. AGE: Years	Months	Days	If less than one day hr.	min.
52	8	4		

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER

12. Name Thomas Fox

13. Birthplace Va.

MOTHER

14. Maiden Name Julia Harrison

15. Birthplace Va

16 (a) Informant Chas Burrow

(b) Address 431 Central Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 13/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem

Location Balto County

18 (a) Funeral director Mrs. Ortie E. Elliott

(b) Address 1129 N. Caroline St.

19 (a) FEB 13 1948 (Date rec'd by registrar) (b) Washington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9 1948, at 1245 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946, to 1948 and that I last saw h[er] alive on Jan 20 1948.

Immediate cause of death Cerebral Hemorrhage

Due to ½ Hemiplegia

Due to generalized Arterio Sclerosis

Due to Chronic Nephritis

Other Conditions Aortic insufficiency

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: None

Duration
1 day
several years

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Ralph J. Young M. D.

Address 1427 E. Monument Date signed Feb 12 1948

VS 150

X

G60117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G60117

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1200 Valley Street

(c) Hospital or institution: Little Sisters of the Poor

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr. 10 mo.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town 1000 Rolling Rd (If outside city or town limits, write RURAL and give town)

(d) Street No. Catonsville (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Peter Thomas (Thomey)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Annie Leeb

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) [illegible] 1852

8. AGE: Years	Months	Days	If less than one day
96		1	hr. min.

9. Birthplace Catonsville, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Michael Thomas

13. Birthplace Germany

MOTHER 14. Maiden Name Margaret Bloom

15. Birthplace Germany

16 (a) Informant Little Sisters of the Poor

(b) Address 1200 Valley St. Baltimore Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-48 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Post Rd

18 (a) Funeral director George A. Farley

(b) Address Fulton & Laurel

19 FEB 13 1948 (Date rec'd by registrar) Huntington Willia[illegible] Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1948, at 12:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb-1 1948, to Feb 11 1948, and that I last saw ~~him~~ alive on Feb-10- 1948.

Immediate cause of death	Duration
Cerebral Arterio Sclerosis	5 yr
Due to	
Due to	
Other Conditions Chronic Myocarditis	3 yr

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. Gill Hall M. D.

Address 1631 E North Ave Date signed 2/11/48

VS 150

660P18 Gordy

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. 660118

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3016 Gibbons Avenue
(c) Hospital or institution: 27-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3016 Gibbons Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Herbert Francis Byors

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Margaret E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 16, 1883

8. AGE: Years	Months	Days	If less than one day
64	1	27	hr. min.

9. Birthplace Marble Head, Mass. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Charles H. Byors
13. Birthplace Mass.

MOTHER
14. Maiden Name Mary Brown
15. Birthplace Mass.

16 (a) Informant Mrs. Margaret E. Byors
(b) Address 3016 Gibbons Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-48 (month) (day) (year)
(c) Cemetery or crematory St. John's Cem.
Location Ellicott City, Md

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 FEB 12 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 193

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12, 1948, at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1943, to Feb 12 1948 and that I last saw h[illegible] alive on Feb 12 1948.

Immediate cause of death Coronary Occlusion — Duration 3 hours
Due to
Due to
Other Conditions Chronic hypertension 5 years
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: No

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury None

23. Signature L. L. Gordy M.D.
Address 5106 Harford Rd Date signed 2/17/48

C60119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 13 B

Registered No. 60119

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 Halcyon Avenue
(c) Hospital or institution: 27-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2601 Halcyon Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME IGNATIUS CHARLES LUBY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Henrietta E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1900

8. AGE: Years	Months	Days	If less than one day
47	8	20	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name John Luby
13. Birthplace Germany

MOTHER 14. Maiden Name R[redacted]
15. Birthplace Poland

16 (a) Informant Mrs. Henrietta E. Luby
(b) Address 2601 Halcyon Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Location

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 FEB 13 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-11 1948, at 1 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 4 1948, to Feb 11 1948. and that I last saw h[redacted] alive on 2-11 1948.

Immediate cause of death

Pulm. Tuberculosis — Duration Sept 1947

Due to

Due to

Other Conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M.W. Jacobs M. D.
Address 2310 Eutaw Place Date signed 2-12-48

VS 150

X

G50120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50120

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5213 Norwood Ave, Baltimore 7, Md
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5213 Norwood Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Walters Bartkowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marie Smead
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr) Oct. 14, 1879

8. AGE: Years	Months	Days	If less than one day
58 68	3	28	hr. min.

1889

9. Birthplace Richmond, Virginia
(Town, county, and state)

10. Usual Occupation Agent, Fruit Growers Expyess

11. Industry or business

FATHER
12. Name John André Bartkowski
13. Birthplace Londonderry Ireland

MOTHER
14. Maiden Name Caroline Walters
15. Birthplace Virginia

16 (a) Informant Robert Leland Bart
(b) Address Sudbrook Park, 8, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 14, 1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Helen Lamoreaux
(b) Address 4510 Liberty Heights Ave.

19 (a) FEB 14 1948 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12 1948, at 7:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from August 15 1947 to February 12 1948, and that I last saw h ing alive on February 12 1948.

Immediate cause of death Coronary thrombosis, Congestive Heart Failure — Duration 3 days

Due to Arteriosclerotic Cardio-vascular disease — 7 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Millard T. Ratcliffe Jr. M.D.
Address 3400 Woodbine Ave, 7 Date signed Feb 12, 1948

VS 150

G60121 AB-117356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G60121 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 5yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 1636 Eastern Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ralph Yoder

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Estelle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4- 1895

8. AGE: Years	Months	Days	If less than one day
52	7	8	hr. min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name Francis
13. Birthplace N.C.

MOTHER
14. Maiden Name Catherine
15. Birthplace N.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/13/48 (month) (day) (year)
(c) Cemetery or crematory
Location Newton, Catawba Co. N. C.

18 (a) Funeral director John J. Connelly
(b) Address 714 Eastern Ave, Essex 21

19 (a) FEB 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION AM

20. DATE OF DEATH Feb. 12- 1948, at 9.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-11- 1948 to 2-12 1948, and that I last saw him alive on 2-12- 1948.

Immediate cause of death	Duration
Cerebral Thrombosis	1½ days
Due to Arteriosalerosis	
Due to	
Other Conditions Arteriosclerotic Heart Disease, CPC of lungs & liver. (Include pregnancy within 3 months of death)	5

Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp Date signed 2-12-48

VS 150

G60122 L. 117320

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G60122

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1hr. 35mi.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 513 Delware Ave. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No) If yes, name country .....

3 (a) FULL NAME Frank Kimmel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ella Buenius
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) March 7, 1885

8. AGE: Years	Months	Days	If less than one day
62	11	3	..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Baltimore City Disposal Plant

FATHER
12. Name Andrew Kimmel
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Hoffman
15. Birthplace Md.

16 (a) Informant Records Balto. City Hospital
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 13-48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Blvd
18 (a) Funeral director John G. Connelly
(b) Address 408 Eastern Blvd.
19 FEB 14 1948 (Date received by Registrar) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1948 at 10-45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1948 to Feb. 10 1948, and that I last saw him alive on Feb. 10 1948.

Immediate cause of death Cerebrovascular accident — Duration [redacted] 2 wks
Due to Hypertension — yrs
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature J. C. Robinson Jr. M. D.
Address Balt. City Hosp. Date signed 2/10/48

VS 150

660123 HINDER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 660123

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Belona Ave
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5100 Palmer Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs Mary Hinder

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
F	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 5th 1865

8. AGE: Years	Months	Days	If less than one day
82	6	8	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Homrighausen
13. Birthplace Germany

MOTHER
14. Maiden Name Anna E
15. Birthplace Balto. Md.

16 (a) Informant W. G. N. Ruckert
(b) Address 1409 Thames St

17 (a) Burial (b) Date thereof 2/16/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 FEB 14 1948 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1948, at 9 00 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1948 to Feb 13 1948, and that I last saw her alive on Feb 13 1948.

Immediate cause of death Cerebral Arteriosclerosis — Duration —

Due to Generalized Arteriosclerosis —

Due to

Other Conditions Arteriosclerotic Cardiovascular Renal
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations —

of autopsy —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John M. Scott M. D.

Address 5 Longwood Rd Date signed Feb 13 48

VS 150

X

460124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 460124

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6000 Bellona Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 604 Radnor Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME John L Thomas

3 (b) If veteran, name war W

3 (c) Social Security Account No.

4 Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Sarah E Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2 1866

8. AGE: Years 81 Months 9 Days 2 If less than one day hr. min.

9. Birthplace Richmond Va (Town, county, and state)

10. Usual Occupation Fireman Retired

11. Industry or business City of Balto

FATHER

12. Name Patrick H Thomas

13. Birthplace Ireland

MOTHER

14. Maiden Name Catherine Erwin

15. Birthplace Ireland

16 (a) Informant Sarah E Thomas

(b) Address 604 Radnor Ave

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 2/16/48 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Woodlawn Md

18 (a) Funeral director Milburn Co Inc

(b) Address 1210 Gay St

19 FEB 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1948, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 9 1948 to Feb 12 1948 and that I last saw him alive on Feb 12 1948.

Immediate cause of death	Duration
Uremia	
Chronic Interstitial Nephritis	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Earl H Benson M.D.

Address 5111 York Rd Date signed Feb 13 1948

VS 153

660125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55B

Registered No. 660125

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2227 Guilford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2227 Guilford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie E. Wade

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Female	White	Married

6 (b) Name of husband ~~or wife~~ Henry N. Wade

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16th 1881

8. AGE: Years	Months	Days	If less than one day
66	5	26	hr. min.

9. Birthplace New York, N.Y.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name H. Bernhart
13. Birthplace Chicago Ill.

MOTHER
14. Maiden Name Elizabeth (?)
15. Birthplace New York, N.Y.

16 (a) Informant Henry N. Wade
(b) Address 2227 Guilford Ave

17 (a) Burial (b) Date thereof 2/16/48
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 FEB 14 1948 Huntington Williams, M.D.
(Date received by local registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12th 1948 at 3:42 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1947, to 12 Feb 1948, and that I last saw h~~er~~ alive on 12 Feb 1948.

Immediate cause of death	Duration
Inanition + Cachexia.	3 mos.
Due to Lymphosarcoma Lt Hip. with	6 mos.
Due to Metastasis to adjoining structures	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Nov 1947

Major findings of operation: Biopsy - Confirming above.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lucretia L. Brown M.D.

Address 1938 Linden Ave Date signed 18 Feb 48

VS 150

160126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 160126

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Dix
(c) Hospital or institution: Balto City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 6
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1319 Eutaw Place
2 N. Madeira St.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Ulrich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of ~~husband or~~ wife: Gertrude Ulrich

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov 27th 1872

8. AGE: Years: 75 | Months: 2 | Days: 15 | If less than one day: hr. min.

9. Birthplace: Harrisburgh Pa.
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business: Boiler Maker

FATHER
12. Name: Unknown Ulrich
13. Birthplace: "

MOTHER
14. Maiden Name: "
15. Birthplace: "

16 (a) Informant: Bernard Ulrich
(b) Address: 2 N. Madeira St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~: Mt. Olivet
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St.

19 (a) FEB 14 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/4 1948, at 8:01 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to h13 death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic CV disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: P. L. Palumbo M.D.
Medical Examiner.
Date signed 2/5/48

X

660127 CM. 116874

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
159

Registered No. 660127

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 18 Willow Ave. Edgemere Z 19
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Armstrong " c " (Bertha)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25 - 1948

8. AGE: Years	Months	Days	If less than one day
		9	hr. min.

9. Birthplace B lto. CO. MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James N. Armstrong
13. Birthplace VA.

MOTHER
14. Maiden Name Bertha Brimm
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 9am 2-6-1948 (month) (day) (year)
(c) Crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) FEB 14 1948 (Date rec'd by registrar) Lillington for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-(4) 5th 1948 at 3.48A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 - 25 - 1948 to 2 - 4 - 1948, and that I last saw her alive on Feb. 2 - 1948.

Immediate cause of death	Duration
Prematurity	
abscess	
Due to	
Due to	
Other Conditions Abscess left groin	4 day

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arnold N Becker M.D.
Address Balto City Hosp Date signed 2/6/48

VS 150

G60128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G60128

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 32nd & Calvert
(c) Hospital or institution: Union Mem. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo 14 da
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mo 14 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Bel Air
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Charles Westley Shaw, Sr (Jennie)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Mr C W Shaw, Sr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 13 1887

8. AGE: Years	Months	Days	If less than one day
60	3	1	— hr. — min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Mr Benjamin Birall
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Hunter
15. Birthplace New York

16 (a) Informant Husband Chas Shaw Sr
(b) Address Bel Air, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 16/48 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Emmorton, Md

18 (a) Funeral director Joseph T Foster
(b) Address Bel Air Md

19 (a) FEB 14 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 1948, at 4:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1947 to Feb 14 1948 and that I last saw h[illegible] alive on Feb 12 1948.

Immediate cause of death Coronary thrombosis, pneumonia

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Jan 27 1948

Major findings of operation: Terminal

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter L. Watkins M. D.
Address Main Mem. Hosp. Date signed 2/14/48

VS 150

660129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 660129

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1513 Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HARRY H. CHANEY

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: C. Pauline Chaney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18, 1886

8. AGE: Years 61 | Months 7 | Days 24 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Balto. Transit Co.
11. Industry or business Retired 5 yrs.

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Mary Catterton
15. Birthplace Unknown

16 (a) Informant Mrs. Harry H. Chaney
(b) Address 1513 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12, 1948, at 2:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1945 to Feb 12 1948, and that I last saw h[im] alive on Feb 11 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	8 years
Due to Essential Hypertension	8 years
Due to Hypertensive Cardio-Vascular Disease	8 years
Due to	
Other Conditions Fracture, neck, left femur	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident 14/1
(b) Date of occurrence December 45 at 2 P M
(c) Where did injury occur? 1513 Park avenue (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury Slipped and fell to floor

23. Signature W. H. Chaney
Address 402 E. Lanvale St. Date signed 2-13-48

Howard J. Mallonee, M.D.

VS 199

660130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Registered No. 660130

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3409 GRANTLEY RD.
(c) Hospital or institution:
(d) Length of stay in ~~hospital or inst. (yrs., mos., or days)~~ ABOVE AI LIFE
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3409 GRANTLEY RD.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME WHEELER LEE BAKER

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 220-07-1467

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife MARY ELIZEBETH
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/11/1911

8. AGE: Years	Months	Days	If less than one day
36	2 3	1	hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)
10. Usual Occupation SALESMAN
11. Industry or business SHIPLEY TRANSFER CO.

FATHER
12. Name WM. W. BAKER
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name MARGARET YOUNG
15. Birthplace BALTIMORE, MD.

16 (a) Informant MRS. MARY E. BAKER
(b) Address 3409 GRANTLEY RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/14/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ LOUDON PK.
Location BALTIMORE, MD.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address WORTH & HA. AVES. BALTO, MD

19 FEB 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/12/48 19__, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-4 1948 to 2-12 1948
and that I last saw h— alive on 2-1 1948.

Immediate cause of death	Duration
Coronary Occlusion	24 hrs
Due to Hypertension Cardiac Vascular Disease	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos J Abbott M. D.
Address 4509 Liberty Heights Date signed 2-13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 152

060131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 060131

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1208 Brentwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Brentwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES E. WARNER

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Mary A. Warner (nee Crafton) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1868

8. AGE: Years	Months	Days	If less than one day
79	3	7 28	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Retired Engineer
11. Industry or business Penn R. R.

FATHER
12. Name Andrew Warner
13. Birthplace

MOTHER
14. Maiden Name
15 Birthplace

16 (a) Informant Mr. Robert M. Warner, son
(b) Address 1208 Brentwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

FEB 14 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11, 1948, at 5:00p M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1948 to 2/11 1948 and that I last saw him alive on 2/11 1948.

Immediate cause of death	Duration
Coronary Thrombosis	12h
Due to Chronic Myocarditis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which place) While at work?
(e) Means of injury

23. Signature Wright L. Tuttle, M.D.
Address 3323 E. Balto St. Date signed 2/13/48

VS 150

G60132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G60132

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 204 N. Pleasant st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian T. Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	colored	widowed

6 (b) Name of husband or wife William Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec-6-1897

8. AGE: Years	Months	Days	If less than one day
50	2	5	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Thomas Isaacson
13. Birthplace West Maryland Cy. Va.

MOTHER
14. Maiden Name Sarah Smith
15. Birthplace West Moreland Cy Va

16 (a) Informant Charles T. Johnson
(b) Address 1422 May St. Douglass Pky

17 (a) Burial (b) Date thereof 2/15/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn - Md.

18 (a) Funeral director Preston Linbury
(b) Address 1421 E. Jefferson st

FEB 14 1948
(Date rec'd by registrar) By [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb - 11 1948, at 9:45 P

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrell M.D.
Medical Examiner.
Date signed 2/12/48

VS 151

660133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 660133

660133

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 800 W. 37th St.
(c) Hospital or institution: 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 800 W. 37th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F. Lindsay

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 215-01-8475

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Martha Spellman
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1874

8. AGE: Years	Months	Days	If less than one day
73	4	11	....hr. ....min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Machinist, Retired
11. Industry or business Continental Can Co.

FATHER
12. Name Richard Lindsay
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Caroline Huglett
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Martha Lindsay
(b) Address 800 W. 37th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/48. (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director Frederick H. Dole
(b) Address 1000 Lombard St

19 FEB 14 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11th 1948, at 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to Feb 11th 1948, and that I last saw h[illegible] alive on Feb 11th 1948.

Immediate cause of death	Duration
(a) Coronary Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward H. Grossman M.D.
Address 2037 Ellwood Date signed 2/12/48

V S 150

G60134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G60134

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Good Samaritan Nursing Home 27 N. Carey
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 19 N. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Monroe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1846

8. AGE: Years	Months	Days	If less than one day
102			hr. min.

9. Birthplace Fayetteville N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name unknown
13. Birthplace " "

MOTHER
14. Maiden Name unknown
15. Birthplace " "

16 (a) Informant Lorin Monroe
(b) Address 1418 E. Madison St

17 (a) Burial (b) Date thereof Feb. 17-1948 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn, Md

18 (a) Funeral director Elroy D. Wilson
(b) Address 1010 Brantley ave

19 (a) FEB 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/5/48 19, at 8:00 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V disease

Due to

Other Conditions Malnutrition

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Fulbrecht M.D.
Medical Examiner.
Date signed 2/6/48

G60135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178a

Registered No. G60135

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A.
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 607 N. Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nelson D. Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace Fork Cane Co Va
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Moore Kane Co

FATHER
12. Name Arthur Carter
13. Birthplace Fork Cane Co Va

MOTHER
14. Maiden Name Ella V. Tuller
15. Birthplace Fork Cane Co Va

16 (a) Informant Virginia Taylor
(b) Address 122 E N. Bay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-48 (month) (day) (year)
(c) Cemetery or crematory Silver Hill Cem
Location Fauquier Co Va

18 (a) Funeral director Elroy S. Wilson
(b) Address 1010 Bloomfield ave

19 (a) FEB 14 1948 (Date received by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/11 1948, at 6:05 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to
Illuminating gas
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 7/5

(a) Date of injury 2/11/48 at about 5:00 P.M.
(b) Where did injury occur? 607 N. Bond St
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Gas heater 5 & 6 burners - not 3 lighted and 3 not lighted

23. Signature H. Galbraith M.D.
Medical Examiner.
Date signed 2/12/48

VS 151

660136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 660136

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University of Maryland Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 da.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 185 Spring St. Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Roberts.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife Corrine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 46 | Months | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Martin Roberts.

13. Birthplace Md.

MOTHER 14. Maiden Name Susie Bowman.

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 15. 1948 (month) (day) (year)

(c) Cemetery or crematory Lakeview Mem. Cem.

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1058 Brantley ave

19 (a) FEB 14 1948 (Date rec'd by registrar) (b) Huntington Wilson, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1948 at 11.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/4 1948 to 2/11 1948 and that I last saw him alive on 2/11 1948

Immediate cause of death Card / Resp. Collapse.

Due to Carcinoma of Stomach

Due to Abdominal Carcinomatosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: Ca of Stomach

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]

Address Redwood & Greene Date signed 2/11/48 M. D.

X

G60137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G60137

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1428 Hollins St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1428 Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Christina Kozjar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Widowed

6 (b) Name of husband or wife Stevens

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? Kozjar
13. Birthplace Austria

MOTHER
14. Maiden Name ?
15 Birthplace Austria

16 (a) Informant Katherine Wiesengoff
(b) Address 1428 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-48 (month) (day) (year)
(c) Cemetery or crematory Russian Orthodox Cem
Location Maxmilla N.J.

18 (a) Funeral director Joseph Kaminskas Jr.
(b) Address 607 Washington Blvd

19 FEB 14 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Feb. 1948, at 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1947 to Feb 1948, and that I last saw her alive 12 Feb 1948.

Immediate cause of death	Duration
Coronary Disease	2 hrs.
Due to Hypertensive C-V. Dis.	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. P. Sullivan M.D.

Address 1445 W Lafayette St Date signed 2/13/48 M. D.

VS 150

X

660138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1213

Registered No. 660138

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mos
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 903 Allegheny ave St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country None

3 (a) FULL NAME Blanche Hicks (Giggie)

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex F

5. Color or race Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/9/1905

8. AGE: Years 43 Months Days 2 If less than one day hr. min.

9. Birthplace Baltimore MD (Town, county, and state)

10. Usual Occupation domestic

11. Industry or business

FATHER 12. Name Joseph Hicks

13. Birthplace md

MOTHER 14. Maiden Name Rosie Handy

15. Birthplace md

16 (a) Informant Mabel Parker

(b) Address 165 N. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/48 (month) (day) (year)

(c) Cemetery or crematory St Peters

Location md

18 (a) Funeral director Geo. D. Kelson

(b) Address 1303 Pennsylvania Ave

19 (a) (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

FEB 14 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/11 1948 6:35 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/12 1947 to 2/11 1948, and that I last saw her alive on 2/11 1948.

Immediate cause of death Chronic Colonitis Nephritis — Duration 1

Due to Uremic

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Chronic Colonitis Nephritis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Williams Garner M.D.

Address 1514 Division St Date signed 2/12/48

BC # 48-1348

660139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 660139

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Welbeck Ave
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1146 Montpelier St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Wht	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			8 hr. 8 min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Richard Martin
13. Birthplace

MOTHER
14. Maiden Name Ada Todd
15. Birthplace S. Carolina

16 (a) Informant Richard N. Martin
(b) Address 1146 Montpelier St

17 (a) Burial (b) Date thereof Feb 15 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bates Baptist Cem
Location

18 (a) Funeral director John C Moran
(b) Address 3600 Kloss St

19 (a) FEB 14 1948 (b) Washington Millimaw M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13 1948 at 430 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/13 1948 to 2/13 1948, and that I last saw her alive on 2/13 1948.

Immediate cause of death	Duration
(Prematurity)	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hugh G Wells M. D.
Address 1 Mayfair Ave Date signed 2/14/48

VS 150

G60140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G60140

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 309 N. Ellwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 N. ELLWOOD AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY L. WARD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	Widowed

6 (b) Name of husband or wife John T. Ward
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1880

8. AGE: Years	Months	Days	If less than one day
68	10	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John C. Batzer
13. Birthplace Maryland

MOTHER
14. Maiden Name Louisa Geis
15. Birthplace Maryland

16 (a) Informant Geo. F. Ward
(b) Address 309 N. Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director John A. Morgan
(b) Address 3000 E. Balt. St.

19 (a) FEB 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13, 1948, at 8 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy & Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to HER death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature WM. G. WELFORD, M.D. PER Medical Examiner M.D.
Date signed 2-13-48

VS 131

660141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 660141

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5531 Bowerbank Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 31 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5531 Bowerbank Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Anne Lefevre Lawrence

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Thomas W. Lawrence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1866

8. AGE: Years 87 | Months 3 | Days 18 | If less than one day hr. min.

9. Birthplace Howard Co., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name George W. Appleby
13. Birthplace Md.

MOTHER
14. Maiden Name Anne Owens
15. Birthplace Md.

16 (a) Informant Mrs. Edith Hogan
(b) Address 5531 Bowerbank Ave Balto

17 (a) Burial (b) Date thereof 2-16-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon
Location Lovegrove, Md.

18 (a) Funeral director C. B. Stacy-Wise
(b) Address Catonsville Md.

19 (a) FEB 14 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13 1946, at 3.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1945, to 2/13 1946 and that I last saw h[illegible] alive on 2/13 1946

Immediate cause of death Coronary Thrombosis — Duration 1 day

Due to Contusion Fracture — Duration 1 day

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address 1801 Eutaw Pl Date signed 2/13/46

VS 150

660142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. 660142

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Williamsport (If outside city or town limits, write RURAL and give town)
(d) Street No. 1158 Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carol Ann Spencer
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	Infant

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-12-45

8. AGE: Years	Months	Days	If less than one day
2	3	1	hr. min.

9. Birthplace Pa (Town, county, and state)
10. Usual Occupation Infant.
11. Industry or business

FATHER
12. Name Henri Spencer
13. Birthplace Mount Pa

MOTHER
14. Maiden Name Jayne Le Joie
15. Birthplace

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-48 (month) (day) (year)
(c) Cemetery or crematory Mountain View
Location Williamsport Pa

18 (a) Funeral director Earl S. Houston
(b) Address 403 E 25th St

19 (a) Date received 2-14-48 (b) Huntington Williamsport, Md. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9 1948 to Feb 13 1948 and that I last saw h[illegible] alive on Feb 13 1948

Immediate cause of death	Duration
Cardiac Failure	
Due to Congenital Disease	2 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 13-Feb-48
Major findings of operation: Transposition of the Aorta
of autopsy: Pulmonal Atresia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel Cantelo M.D.
Address Johns Hopkins Hosp. Date signed 13 Feb 48

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660143

660143 1334

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton & Wilkens Aves.

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 14 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1003 Lyndhurst St (If rural, give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Anna Harrison

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife Late Samuel R. Harrison

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1880

8. AGE: Years	Months	Days	If less than one day
67	7	13	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name James O'Donovan (deceased)

13. Birthplace Ireland

MOTHER

14. Maiden Name Anna ? (deceased)

15. Birthplace Ireland

16 (a) Informant Mrs. George H. Spicer

(b) Address 1003 Lyndhurst St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location 4300 Old Frederick Rd.

18 (a) Funeral director Harry N. Nitkin

(b) Address 4101 Edmondson Ave

19 (a) Date rec'd by Reg. 2-13-48 (b) Countersigned for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/12 19 48 at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/8 19 42 to 2/12 19 48 and that I last saw her alive on 2/12 19 48

Immediate cause of death	Duration
Uremia	
Due to Acute pyelonephritis	
Due to Ascending urinary tract infection	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: cystitis & pyelonephritis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Herbert J. Lovelace

Address St Agnes Hosp. Date signed 2/12/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C60144

C60144 BC: C 22156 107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 31 N. Kreason St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country — — —

3 (a) FULL NAME Richard McBride

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months 8 | Days | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER
12. Name John McBride
13. Birthplace Ireland

MOTHER
14. Maiden Name Leonora Schuman
15. Birthplace Maryland

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 2-14-48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. East

18 (a) Funeral director Lilly & Zeiler Inc
(b) Address 403 S. Wolfe St.

19 (a) (Date rec'd by Registrar) **(b)** Hunnington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1948, at 9-30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-24 1948 to Feb 12 1948, and that I last saw h[illegible] alive on Feb 12 1948

Immediate cause of death Pneumonia + atelectasis — Duration 2 days

Due to

Due to — over

Other Conditions Emphysema + Cirrhosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address Johns Hopkins Hosp. Date signed 2-14-48

X

660145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. 660145

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 321- Moore Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimae. (If outside city or town limits, write RURAL and give county)

(d) Street No. 321- Moore Stree (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Addie Boardley.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fem. 5. Color or race Col. 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19 1881

8. AGE: Years 66 Months 4 Days 22 If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Thomas

13. Birthplace Md.

MOTHER 14. Maiden Name ?

15. Birthplace Md

16 (a) Informant Richard Boardley

(b) Address 321- Moore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director A. Halstead

(b) Address 918- Hend Hill

19 (a) FEB 14 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-11- 1948 at 3:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1948 to Feb 11 1948. and that I last saw him alive on Feb 11 1948.

Immediate cause of death: Carcinoma Liver & Contributory

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
7 months

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify kind of place)

(e) Means of injury

23. Signature [illegible] M.D.

Address [illegible] Date signed 2-13-48

X

VS 150

G60146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8 3a

G60146

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 582 - St. Mary St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town 582 - St. Mary St.

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Lula Luber Johnson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Fem.

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1902

8. AGE: Years 46 | Months 1 | Days | If less than one day hr. min.

9. Birthplace S. C.

(Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER 12. Name Glenn Bates

13. Birthplace S. C.

MOTHER 14. Maiden Name Layra Bowen

15. Birthplace Lillie S. C.

16 (a) Informant Lillie Drake

(b) Address 582 - St. Mary St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/48 (month) (day) (yr.)

(c) Cemetery or crematory Cherry Grove

Location Columbia S. C.

18 (a) Funeral director A. Halstead Hill

(b) Address 918 - Lenud Hill Ave.

19 (a) (Date rec'd by Registrar) (b) Washington Virginia (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-10-1948 at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/2 1948 to 2/10 1948 and that I last saw her alive on 2/10 1948.

Immediate cause of death: Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address Date signed 2/13/48

VS 150

660147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

660147 Registered No. 1190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Alexandria (If outside city or town limits, write RURAL and give town)
(d) Street No. 3 or Mile Post (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Allen Dee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-25-47

8. AGE: Years 0 | Months 3X | Days 19 | If less than one day ___ hr. ___ min.

9. Birthplace (town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name George L. Dee
13. Birthplace Ky

MOTHER
14. Maiden Name Helen Tanner
15. Birthplace N.J.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-14-48 (month) (day) (year)

(c) Cemetery or crematory
Location Washington D.C.

18 (a) Funeral director W. R. Speare & Sons
(b) Address 2901 14th St. N.W.

19 (c) FEB 14 1948 (Date rec'd by registrar) (b) Washington, Nebraska, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-13-48, 19..., at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15-48, 19..., to 2-13-48, 19..., and that I last saw h[illegible] alive on 2-13-1948.

Immediate cause of death Pneumonia & Empyema — Duration 27 Days

Due to

Due to

Other Conditions Unfavorable Non-Labor

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address [illegible] Date signed 2-14-48

X

660148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310

Registered No. 660148

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1449 Hull St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1449 Hull St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary R. Ross

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife James Ross
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Sept. 14. 1882

8. AGE: Years	Months	Days	If less than one day
65	5 4	28	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name James Marling
13. Birthplace Baltimore

MOTHER
14. Maiden Name Rose Fitzpatrick
15. Birthplace Baltimore

16 (a) Informant Elizabeth Boswell
(b) Address 1449 Hull St. daughter

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie

18 (a) Funeral director Charles F. Weil
(b) Address 1501 E. Fort Ave

19 (a) Date received by Registrar FEB 14 1948 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1948, to Feb. 12 1948; and that I last saw h[illegible] alive on February 11 1948.

Immediate cause of death	Duration
Hemorrhage a	4 d
Bronchio Pneumonia	3 d.
Due to Malignant Regurgitation	4 3 d.
Due to Chronic Parenchymatous Nephritis	4 5 d.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None.
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. S. A. Stevens M. D.
Address 2818 Harford Rd Date signed 2-12-48

VS 150

160149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. 160149

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1934 McCulloh St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Robertson-Ed

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Helen

6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) 12-15-07.

8. AGE: Years	Months	Days	If less than one day
40	1	29	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Charles Robertson-Ed

FATHER 13. Birthplace Va

MOTHER 14. Maiden Name Adelaide L.

MOTHER 15. Birthplace Va

16 (a) Informant Records JOHNS HOPKINS HOSPITAL

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-48 (month) (day) (year)

(c) Cemetery or crematory Scottsville Va

Location

18 (a) Funeral director George B. Nelson

(b) Address 1303 Presstman St

19 FEB 14 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb - 13 1948, at 3:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 11 1948 to Feb 13 1948 and that I last saw him alive on Feb 13 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Thrombocytopenia	
Due to Myelogenous Leukemia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Sherman Mellinkoff D

Address Johns Hopkins Hosp Date signed 2-13-48

VS 150

X

660150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 660150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 539 N. Washington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 539 N. Washington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Otto G. Witzell

3 (b) If veteran, name war: No.

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) May 14 1877

8. AGE: Years 70 | Months 8 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Otto Witzel
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Pfingstler
15. Birthplace Germany

16 (a) Informant Anna Witzel
(b) Address 539 N. Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd

18 (a) Funeral director Dippel Bros.
(b) Address 1800 E Lombard St

19 FEB 14 1948 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1948 at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 1948 to 2/13 1948, and that I last saw her alive on 2/12 1948.

Immediate cause of death: Case. Pulm Oedema — Duration 24 hrs

Due to: Chronic Myocarditis

Due to: Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fred J. Sudler, M.D.
Address 2323 E Baltimore St Date signed 3/13/48

660151 JL - 84202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. 660151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 Ridgley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Moser

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: No

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: CKate Moser

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1864

8. AGE: Years 83 | Months 7 | Days 20 | If less than one day hr. min.

9. Birthplace Md. Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Adam Moser
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine ? Kate
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Western
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves; Balto., Md.

19 (a) FEB 14 1948 (Date rec'd by registrar) (b) [illegible] for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12 1948, at 11P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 6 1943 to Feb. 12 1948, and that I last saw him alive on Feb. 12 1948.

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions Arterio Sclerosis, arteriosclerotic nephrosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. T. Bamford M. D.
Address Balt. City Hosp. Date signed 2-13-48

VS 150

107

660152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

660152
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Ruthland
(c) Hospital or institution:
Siani Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) --

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Norfolk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 E. 26th St.
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME AARON WEISMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Married

6 (b) Name of husband or wife Gussie Weisman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) About 1880

8. AGE: Years	Months	Days	If less than one day
About 67		7	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15 Birthplace

16 (a) Informant
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/14/48 (month) (day) (year)
(c) Cemetery or crematory
Location Norfolk, Virginia

18 (a) Funeral director W. J. TICKNER & SONS INC
(b) Address North & Pa. Aves; Balto., Md.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

FEB 14 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14 1948, at 7:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/9/ 1948 to 2/14 1948, and that I last saw him alive on 2/14 1948.

Immediate cause of death	Duration
Pulmonary Edema	
Due to Cardiac Failure	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 2/12/48
Major findings of operation: Carcinoma of Stomach. Total gastrectomy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Maurice A. Perella
Address Sinai Hosp Date signed 2/14

X

660153

BC-48-02243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 660153

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2622 Puget St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: HAROLD SYLVESTER SCOTT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/2/48

8. AGE: Years | Months | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Scott.
13. Birthplace Virginia

MOTHER
14. Maiden Name Alda Jackson.
15. Birthplace Md.

16 (a) Informant Mrs. John Scott.
(b) Address 2622 Puget St.

17 (a) Burial (b) Date thereof Feb. 14, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) (b) Registrar
(If delayed, by registrar)

FEB 15 1948

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13, 1948, at 2.25 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Reyer M.D.
Medical Examiner.
Date signed 2-14-48

C60154

BC-48-02383

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 179X

C60154

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 15-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2227 Braddish Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eliott Rubinstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 29 1948

8. AGE: Years | Months | Days 14 days | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Albert Rubenstein
13. Birthplace Baltimore

MOTHER
14. Maiden Name Bernice Kamoroff
15. Birthplace Baltimore

16 (a) Informant Albert Rubinstein
(b) Address 2227 Braddish Ave.

17 (a) BURIAL (b) Date thereof 2 15 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HEBREW HERRING ROW
Location BOWLEY'S LANE

18 (a) Funeral director S. L. LEVINSON & BROS
(b) Address 1124-26 W. NORTH AVE.

19 (a) (b)
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13, 1948, at 4.28 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Boric acid poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-10-48 at ? 15/7 M.
(b) Where did injury occur? 2227 Braddish Ave. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury. Ingestion of boric acid.

23. Signature Earl L. Brady M.D.
Medical Examiner.
Date signed 2-14-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 181

G60155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 937

Registered No. G60155

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 S. Curley
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 703 S. Curley st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Janowiak

3 (b) If veteran, name war

3 (d) Social Security Account No. 216-09-8106

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Helen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 25 1884

8. AGE: Years	Months	Days	If less than one day
63	10	19	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation sheet metal worker

11. Industry or business Stewart & Mitchell

FATHER
12. Name Frederick Janowiak
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Mrs. Helen Janowiak
(b) Address 703 S. Curley st.

17 (a) Burial (b) Date thereof 2/17/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus
Location Dundalk ave

18 (a) Funeral director Fitzpatrick Frankowski Inc
(b) Address 1008 S. Linwood ave

19 (a) Date rec'd by Registrar (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13 1948, at 445 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Feb 13 1948 and that I last saw h.. alive on Feb 13 1948.

Immediate cause of death	Duration
Coronary Occlusion	Feb 11/48
Due to Ch. Myocarditis	July 1 1945
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William R Roarer M.D.
Address 801 N Kenwood Ave Date signed 2/19/48

VS 150

R 660156
BC-C-31546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓107

C60156
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The coroner is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 Monroe Circle
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Buxton (Buck) Wayne Kimble.
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 5-27-47

8. AGE: Years	Months	Days	If less than one day
	7	18	hrs. min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Melvin Kimble
13. Birthplace Md.

MOTHER
14. Maiden Name Gwendolyn Anderson
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Feb 16-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park Cem.
Location Frederick Road
18 (a) Funeral director Milton Schilling
(b) Address 3914 S. Hanover St
19 (a) (Date rec'd by registrar) (b) Huntington, Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14, 1948, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 13 1948, to Feb 14 1948 and that I last saw him alive on Feb 14 1948

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature A. M. Edmonds
Address J. Hopkins Hosp. Date signed 2-14-48

G60157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G60157 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1511 Madison Ave.
(c) Hospital or institution:

14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daisy Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1889

8. AGE: Years	Months	Days	If less than one day
58	8	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Notary Public

11. Industry or business

FATHER
12. Name Charles Wilson
13. Birthplace Md.

MOTHER
14. Maiden Name Martha Lemon
15. Birthplace Md.

16 (a) Informant Mrs. Bessie W. Brown
(b) Address 1511 Madison Ave.

17 (a) Burial (b) Date thereof 2-16-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cem.
Location Landsdowne, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 1578 W. Biddle St.

FEB 15 1948
(Date rec'd by registrar)

(b) Huntington Millinery Hdqrs.

MEDICAL CERTIFICATION P

20. DATE OF DEATH February 13, 1948, at 3:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28 1948 to Feb 13 1948 and that I last saw her alive on Feb 12 1948.

Immediate cause of death	Duration
Cerebral Hemmorhage.	
Due to Hypertension	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Garland Grinnell Jr. M. D.
Address 912 W. Franklin Date signed 2-14-48

V S 150

X

G60158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G60158 Registered No. 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1501 W. Saratoga St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 W. Saratoga St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Ennis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1881

8. AGE: Years	Months	Days	If less than one day
67	-	29	hr. min.

9. Birthplace Howard Co., Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Leah Ennis
13. Birthplace Md.

MOTHER
14. Maiden Name Amanda Jackson
15. Birthplace Md.

16 (a) Informant Mrs. Ida Brincor
(b) Address 332 Camel St.

17 (a) Burial (b) Date thereof 2-17-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Ffances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13, 1948 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1948 to Feb 11 1948.
and that I last saw h.er alive on 2/10/48 19

Immediate cause of death	Duration
Myocardits	days from
Due to Uremia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm F. Jordan M. D.
Address 401 Edmondson Date signed 2/14/48

V S 150

G60159

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G60159 Registered No. 12/a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 715 Dolphin Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 715 Dolphin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Watkins

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-14-8842

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Mary Watkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1881

8. AGE: Years	Months	Days	If less than one day
67	-	24	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Daniel Watkins
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Mary Watkins
(b) Address 715 Dolphin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-15-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date rec'd by registrar) (b) Huntington Nitkin Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH Feb. 11, 1948, at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-22 1948 to 2-11 1948, and that I last saw h[illegible] alive on 2-11 1948

Immediate cause of death Cerebral Hemorrhage — Duration
Due to Hypertensive Cardiovascular Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 805 N. Freemason St. Date signed 2-12-48

FE 350

G60160

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 108

G60160
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 303 S. Fremont Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret White

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex: F
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) ? ? 1894
8. AGE: Years 54 | Months ? | Days ? | If less than one day hr. min.
9. Birthplace Frederick, Va. (Town, county, and state)
10. Usual Occupation Maid
11. Industry or business Seafarer

FATHER
12. Name James White
13. Birthplace Va. (Spottsville)

MOTHER
14. Maiden Name Mary Boswell
15 Birthplace Va. (Spottsville)

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) FEB 5 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13 1948, at 12:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 9 1948 to Feb 13 1948, and that I last saw her alive on Feb. 13 1948.

	Duration
Immediate cause of death: Nephrosis, acute, etiology undetermined	2 wks.
Due to: Lobar pneumonia, right upper lobe	2 wks.
Due to: Fatty metamorphosis of liver	Unknown
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 2/13/48 M.D.

VS 150

X

G60161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G60161 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 522 Johnson st.
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or towp limits, write RURAL and give town)
(d) Street No. 1514 Division (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Wadsworth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace N.C (Town, county and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Allen Wadsworth
13. Birthplace N. C

MOTHER
14. Maiden Name Mary Jones
15. Birthplace N C

16 (a) Informant Weldon Dill Wadsworth
(b) Address 330 N Bruce Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto Md

18 (a) Funeral director Isaiah G Brandt Son
(b) Address 1086 Montgomery Street

19 (a) (Date rec'd by registrar) (b) Registrar
FEB 16 1948 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9 1948, at 3 00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 1948 to 2/9 1948, and that I last saw h alive on 2/5 1948

Immediate cause of death	Duration
Cerebral Thrombosis	
Due to Hypertensive C-V Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Preston Grant M. D.
Address 1514 Division Date signed 2/10/48

C60162

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

C60162 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3709 Chesholm Road
(c) Hospital or institution: 15 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 48 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3709 Chesholm Road
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ---------

3 (a) FULL NAME: John Curtis Price

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Marie Estelle Stone

6 (c) If alive, give age ---years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1857

8. AGE: Years 90 | Months 1 | Days 24 | If less than one day --hr. ---min.

9. Birthplace: Somerset County, Md.
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business: -------

FATHER
12. Name: William A. Price
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Ann R. White
15. Birthplace: Maryland

16 (a) Informant: Miss Ora M. Price
(b) Address: 3709 Chesholm Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/48 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore, Md.

18 (a) Funeral director: H. W. Mears and Son
(b) Address: 805 N. Calvert Street

19 (a) (Date rec'd by registrar) Wellington Williams M.D. Registrar

FEB 15 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13 1948, at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 21 1947 to Feb. 14 1948; and that I last saw h[illegible] alive on Feb. 14 1948.

Immediate cause of death: Renal Arteriosclerosis — Duration

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Wm Dehmert

Address 701 N. Howard St. Date signed 2/4/48

X

660163

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

660163

Registered No. 50

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: U.S. MARINE HOSP. BALTO MD
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 24 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna (b) County
(c) City or town Pittsburgh (If outside city or town limits, write RURAL and give town)
(d) Street No. 248 FISK ST (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME JERMALOWSKI, Rose Leonardo

3 (b) If veteran, name war —
3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/31/96

8. AGE: Years	Months	Days	If less than one day
51	5	13 14	hr. min.

9. Birthplace Pittsburgh Penna (Town, county, and state)
10. Usual Occupation Attendant at Nurses
11. Industry or business Home USMH Pittsburgh

FATHER
12. Name Adolph Jermalowski
13. Birthplace Russia

MOTHER
14. Maiden Name Julia Frankowsky
15. Birthplace Germany

16 (a) Informant Hospital Records
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/15/48 (month) (day) (year)
(c) Cemetery or crematory
Location Pittsburgh Pa.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) Date received by Registrar FEB 16 1948 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 1948, at 7 15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 21 1948, to Feb 14 1948, and that I last saw h.e.r. alive on Feb. 14 1948.

Immediate cause of death	Duration
METASTATIC CARCINOMATOSIS	?
Due to ADENOCARCINOMA BREAST,	1yr
Due to RIGHT	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation JAN 22, 1948
Major findings of operation: Adenocarcinoma R. breast generalized metastases

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Andrew J. Mathewson M. D.
Address O.D. BALTO. MARINE Hosp. Date signed 2/14/48

Correct name, address, and other data must be given. The exact date of birth and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G60164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G60164

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4660 Park Heights Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore, MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4660 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Elizabeth Streett Amos

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife B. Scott Amos
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1854

8. AGE: Years	Months	Days	If less than one day
93	2	25	hr. min.

9. Birthplace Harford Co., MD
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name John Streett
13. Birthplace Harford Co. MD.

MOTHER
14. Maiden Name Lucilla Johns
15. Birthplace Harford Co., MD.

16 (a) Informant Miss Mary D. Amos
(b) Address 4660 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. MD.

18 (a) Funeral director Wm. J. Tickner & Sons Inc.
(b) Address Baltimore, MD.

19 (a) FEB 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-12-48 19.. 11 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/8/48 19.. to 2/12/48 19.., and that I last saw h or alive on 2/11/48 19..

Immediate cause of death Arterio-sclerotic Myocarditis — Duration

Due to Generalized Arterio-sclerosis

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Julius C. Bluck M. D.
Address 5356 Reisterstown Rd Date signed 2/14/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G60165

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46 B

G60165
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stoney Run Lane
(c) Hospital or institution: Hillcrest Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 W. University Pkwy. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BESSIE CRENEY

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 4, 1875

8. AGE: Years	Months	Days	If less than one day
72	2	9	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Shopper
11. Industry or business Stewart & Co.

FATHER
12. Name Wm. T. Creney
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Elizabeth Tipton
15. Birthplace ?

16 (a) Informant Mrs. J. O. Ziegfeld
(b) Address 591 Gladstone Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13, 1948, at 4:30 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1938 to Feb. 13 1948, and that I last saw her alive on Feb. 12 1948.

Immediate cause of death	Duration
Carcinomatosis	1 mo.?
Due to Cancer of stomach	2 mon.?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Jan. 13, 1948
Major findings of operation: Carcinoma of stomach; extensive metastases.
of autopsy: Same as at operation.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robt. B. Wright M. D.
Address Medical Arts Bldg. Date signed 2/14/48

X

VS 150

660166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a

Registered No. 660166

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 9 hrs. 40 min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 205 E. 33rd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: William David Rusby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Wm D. Rusby

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1884

8. AGE: Years 63 | Months 2 | Days 27 | If less than one day hr. min.

9. Birthplace Washington, D.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name David Rusby
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Taylor
15. Birthplace Virginia

16 (a) Informant: Wife
(b) Address 205 E. 33rd St. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-12-48 19 at 9:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-12 19 48 to 2-12 19 48 and that I last saw h alive on 2-12 19 48

Immediate cause of death (a) Intestinal Perforation Duration
~~Acute coronary artery~~
perforating peptic ulcer.
Due to (b) Arteriosclerotic hypertensive cardiovascular disease
Due to
Other Conditions Mild congestive failure, Diabetic Mellitus & acidosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Clarke M. D.
Address UMH Date signed 2-13-48

VS 150

X

G60167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G60167

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1923 W. Baltimore St.
(c) Hospital or institution: 20-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1923 W. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mina Ellis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Benjamin Ellis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1878.

8. AGE: Years	Months	Days	If less than one day
69	4	11	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation H. W.
11. Industry or business

FATHER
12. Name Winchester
13. Birthplace Md.

MOTHER
14. Maiden Name Emilie J. ———
15. Birthplace Md.

16 (a) Informant Mr. Benjamin Ellis
(b) Address 1923 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 16/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Kuhlke
(b) Address 4101 Edmondson Ave.

FEB 15 1948

19 (a) (Date rec'd by registrar) (b) (Registrar)

VS 150

Lurington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13/48. 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1946 to Feb 13 1948 and that I last saw h[illegible] alive on Feb 11 1948

Immediate cause of death	Duration
General Carcinomatosis	10 Months
Due to Osteomas of Breast left	2 years
Due to Pathological fracture Right Femur	11/1947
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edith W. Johnson M. D.
Address 3432 Druid Park Ave. Date signed 2/14/48

X

G60168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G60168 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 15-8

(a) Baltimore City, Maryland

(b) Street address Dukeland & Rayner Aves.

(c) Hospital or institution: West Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3401 Gwynns Falls Pkwy (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma Hanley Myers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife John A. Myers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1884

8. AGE: Years	Months	Days	If less than one day
63	3	13 3	hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name William Hanley

13. Birthplace Pa.

MOTHER

14. Maiden Name Ida Smith

15. Birthplace Pa.

16 (a) Informant John A. Myers

(b) Address 3401 Gwynns Falls Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 17/48 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park

Location Woodlawn, Md.

18 (a) Funeral director Harry A. Little

(b) Address 4101 Edmondson Ave.

19 (a) Date received by registrar (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-13 1948, at 10:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-9 1948 to 2-13 1948 and that I last saw h er alive on 2-13 1948.

Immediate cause of death: Myocardial Infarction, Coronary Arteriosclerosis

Due to: Arteriosclerotic Hypertension, Cardiovascular Renal

Due to:

Other Conditions: Carcinoma of Left Breast

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. W. Bintzmon M.D. M. D.

Address W. B. Gen Hosp. Date signed 2-13-48

937

C60169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

C60169
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3501 Chestnut ave
(c) Hospital or institution: 13-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3501 Chestnut ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Annie L. Deltz

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Clarence E Deltz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 25 1880

8. AGE: Years	Months	Days	If less than one day
68	0	18	hr. min.

9. Birthplace Carroll Co Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

MOTHER | FATHER

12. Name John W Horton

13. Birthplace Md

MOTHER

14. Maiden Name Annie D. Deltz

15. Birthplace Md

16 (a) Informant Mr Clarence E Deltz

(b) Address 3501 Chestnut ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-48 (month) (day) (year)

(c) Cemetery or crematory Pipe Creek Cem
Location Carroll Co Md

18 (a) Funeral director Geo L Beyer Jr

(b) Address 1512 Hollins St

19 (a) 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13 1948, at 9 25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8 1947 to Feb 13 1948, and that I last saw h[illegible] alive on Feb 13 1948.

	Duration
Immediate cause of death Endocarditis Chronic Industrial Arthritis	
Due to Carcinomatosis of	
Due to Cerebral with Metastasis	
Other Conditions Hypertensive Congestive	48 hrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H A Dooley

Address 1 Medical Arts Bldg Date signed Feb 15 1948
M. D.

660170 BALTIMORE CITY HEALTH DEPARTMENT 660170
Registered No.

CERTIFICATE OF DEATH 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1157 N. Mount St
(c) Hospital or institution: 16-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1157 N. Mount St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles R. Batts

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Emma Batts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept 26, 1912

8. AGE: Years: 35 | Months: 4 | Days: 15 | If less than one day: hr. min.

9. Birthplace: Rocky Mount, N.C. (Town, county, and state)

10. Usual Occupation: Machine Operator

11. Industry or business

FATHER
12. Name: Charles Batts
13. Birthplace: Rocky Mount, N.C.

MOTHER
14. Maiden Name: Nahie Savage
15. Birthplace: Rocky Mount, N.C.

16 (a) Informant: Emma Batts
(b) Address: 1157 N. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 15, 1948 (month) (day) (year)
(c) Cemetery or crematory: Mt Auburn Cem
Location:

18 (a) Funeral director: Wm Kate K. Williams
(b) Address: 922 N. Schroeder St

19 (a) FEB 1 1948 (Date filed by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11, 1948, at 3:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5-1948 to 2-11-1948 and that I last saw him alive on 2-10-1948.

	Duration
Immediate cause of death: Coronary Thrombosis	one week
Due to: Coronary Sclerosis	9
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: John E. J. Camper M. D.
Address: 639 N. Carey St Date signed: 2-14-48

VS 150

X

G60171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G60171 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1711 HOLLINS St
(c) Hospital or institution: 19-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 HOLLINS St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3. (a) FULL NAME MARY THON

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex: FEMALE | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: CHRISTIAN THON

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) ? 1874

8. AGE: Years 74 | Months | Days | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business None

MOTHER / FATHER

12. Name — BUCKSTIEN

13. Birthplace —

14. Maiden Name —

15. Birthplace —

16 (a) Informant MARQUERITE SPILLMAN

(b) Address 1184 CLEVELAND St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 16, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location Balto Md

18 (a) Funeral director Roth & B. M. Walter

(b) Address Pratt & Stricker Sts

19 FEB 16 1948 (Date rec'd by registrar) (b) Huntington Williamsport MD

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12 1948, at 6:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from February 1944 to February 12 1948 and that I last saw her alive on Feb 11 1948.

	Duration
Immediate cause of death: Arteriosclerotic myocarditis	4 yrs.
Due to: Generalized arteriosclerosis	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. B. Thrasher M. D.

Address 324 S. Fulton Ave Date signed 2-14-48

VS 150

660172

BALTIMORE CITY HEALTH DEPARTMENT

BC 48-03439 CERTIFICATE OF DEATH 159

660172
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 LIGHT St.
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (years or days) 1
(e) Length of stay in Baltimore (years or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore 25
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4409 Shear Ct. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Leonard BABY E BOY CORSEY Coursey

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: S
6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-13-48

8. AGE: Years 0 | Months 0 | Days 1 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Ernest Coursey
13. Birthplace Md.

MOTHER
14. Maiden Name Lillian Connor
15. Birthplace Md

16 (a) Informant Ernest Father Coursey
(b) Address 1413 Daniel St Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Fredk. Ave

18 (a) Funeral director E. W. Lippencott
(b) Address 1003 W. Baltimore St

19 (a) FEB 16 1948 (Date rec'd by registrar) (b) Waiting for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-14-1948 at 8:05 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-13-1948 to 2-14-1948 and that I last saw him alive on 2-14-1948.

Immediate cause of death	Duration
Resp Failure	
Due to Prematurity	24 hrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H D Cooper M. D.
Address 1213 Light St Date signed 2-15-48

VS 150

G60173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G60173
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1230 Hanover St
(c) Hospital or institution: 232

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 Olive St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Abey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Albert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 1866

8. AGE: Years 81 | Months 9 | Days | If less than one day hr. min.

9. Birthplace Cambridge Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs Catherine Miller
(b) Address 1610 Olive St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Baltimore Md

18 (a) Funeral director Wilson Cook Inc
(b) Address 1217 E Pratt St

19 (a) FEB 16 1948 (Date rec'd by registrar) (b) Hunter for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1948, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947, to Feb 13 1948, and that I last saw her alive on Feb 13 1948.

Immediate cause of death	Duration
Edema of Lungs and Exhaustion	2 days
Due to Arteriosclerosis	
Due to Cerebral Hemorrhage	1 Year
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. L. Campbell M. D.
Address 1644 Hanover Date signed 2/14/48

G60174

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G60174 Registered No. 1084

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 23-3
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1621- Race Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) **FULL NAME** ADELAIDE J. POOLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Geo R Poole
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12-1897

8. AGE Years	Months	Days	If less than one day
50 51	11	1	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Waitress
11. Industry or business

FATHER
12. Name Otto Paul
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Schleming
15. Birthplace Holland

16 (a) Informant Mrs C A Holmes
(b) Address Yonnuta Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Gilbert Cook Co
(b) Address 1319 E Lexington St

19 (a) FEB 16 1948 (Date rec'd by registrar) (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13, 1948, at 11.25 a.m.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar pneumonia

Due to

Other Conditions Fatty degeneration of liver
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 2-13-48

G601175

BALTIMORE CITY HEALTH DEPARTMENT

BC48-02809 CERTIFICATE OF DEATH ✓ 160a

Registered No. G601175

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 147 Oaklee Village (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Coogan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2/7/48

8. AGE: Years	Months	Days	If less than one day
		8	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Gerard Coogan
13. Birthplace New York, N.Y.

MOTHER
14. Maiden Name Bernice Krohn
15. Birthplace Chicago. Ill.

16 (a) Informant Gerard Coogan
(b) Address 147 Oaklee Village Balto. 29

17 (a) 2/16/48 (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul Street

19 (a) FEB 16 1948 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15th 1948, at 2:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h~~im~~ alive on Feb 15 1948.

Immediate cause of death	Duration
Respiration failure	
Due to Prematurity	
Due to	
Other Conditions Intracranial Hemorrhage	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hugh A Wells M. D.
Address Stevens Bldg Date signed 2/16/48

VS 150

159

660176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310

Registered No. 660176

660176

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2210 Orleans St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2210 Orleans St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Paul Fischer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Stella Fischer
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Nov 14th 1881

8. AGE: Years	Months	Days	If less than one day
66	2	29	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation General Utility
11. Industry or business

FATHER
12. Name Louis C Fischer
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Rosenberger
15. Birthplace Germany

16 (a) Informant Stella Fischer
(b) Address 2210 Orleans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 16- (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans

19 (a) FEB 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby 13 1948, at 9:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/27 1947 to 2/13 1948, and that I last saw h/m alive on 2/8 1948.

Immediate cause of death	Duration
Coronary Thrombosis	1 week
Due to Arteriosclerotic Cardio-Vascular Renal Disease	7 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph S. Blum M.D.
Address 120 E. Preston St Date signed 2/14/48

VS 150

X

G60177

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

53

Registered No. G60177

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3½ mos
(e) Length of stay in Baltimore (yrs., mos., or days) 3½ mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State R.I. (b) County
(c) City or town Providence
(If outside city or town limits, write RURAL and give town)
(d) Street No. 341 Willard Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Vincent King

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	035-18-5574

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife: none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1912

8. AGE: Years	Months	Days	If less than one day
36	11	29	hr. min.

9. Birthplace: Providence, R.I.
(Town, county, and state)
10. Usual Occupation: Boatswain
11. Industry or business: Seafarer

FATHER
12. Name: Hugh King
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Rose Munn
15. Birthplace: Ireland

16 (a) Informant: Records
(b) Address: U. S. Marine Hospital

17 (a) Burial [illegible] (b) Date thereof 2/16/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Francis
Location Providence R. I.

18 (a) Funeral director D. D. Foley Son
(b) Address 1218 Light St.

19 (a) FEB 16 1948 (b) Lington Williams, M.D.
(Date received by local registrar) (Signature of local registrar)

VS 15a

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15, 1948, at 1:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 30 1947, to Feb. 15 1948, and that I last saw him alive on Feb. 15 1948.

Immediate cause of death	Duration
Melanoma, Malignant, Metastatic to Mediastinum, Lungs, Liver, ~~Brain~~ Kidneys	
Primary Skin R. Buttock	Unknown
~~Duo~~ removed 1943	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin Corbin M.D.
Address U.S. Marine Hosp. Baltimore, Md. Date signed 2/15/48

X

660178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

660178 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2910 Reisterstown Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 Reisterstown Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah F Cohen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Aaron

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 66 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Kolman Gerber
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie
15 Birthplace Russia

16 (a) Informant Sylvan Cohen
(b) Address 3734 Beehler Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-48 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herring Run

18 (a) Funeral director Jack Kelvin Inc
(b) Address 2100 Eutaw Place

19 (a) FEB 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-14- 1948, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/15 1947, to 2/14 1948.
and that I last saw her alive on 2/14 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 9 hours
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry D. McCarty M.D.
Address 37 W Preston St Date signed 2/15/48

VS 159

G60179

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 95c

Registered No. G60179

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2476 Shirley Ave 15-13
(c) Hospital or institution: Mt Carmel Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2476 Shirley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose Taylor

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1858

8. AGE: Years 90 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Mrs I Israelson
(b) Address 2514 Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-48 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herzung Rem

18 (a) Funeral director Jack Lewis Inc
(b) Address 2109 Eutaw Place

19 (a) FEB 16 1948 (Date rec'd by registrar) (b) Huntington Williams Mortuary Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-15-1948, at 10:15 M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 27 1948 to Feb 15 1948 and that I last saw deceased alive on Feb 15 1948

Immediate cause of death: Cardiac failure
Due to: Arteriosclerosis & Chronic Congestive
Due to: Heart Disease

Duration
1 day
14 yrs

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M D Baylin
Address 2040 Eutaw Date signed 2/16/48

VS 150

X

G60180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G60180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1519 No Bentelaw St
(c) Hospital or institution 15-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 39yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 No Bentelaw St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Bulmash

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Abraham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1874

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Samuel
13. Birthplace Russia

MOTHER
14. Maiden Name Gertrude
15. Birthplace Russia

16 (a) Informant Samuel Bulmash
(b) Address 801 No Bentelaw St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-48 (month) (day) (year)
(c) Cemetery or crematory Windsor Mill
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 2166 Eutaw Place

19 FEB 16 1948 (Date rec'd by registrar) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-15- 1948 at 6:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/12 1948 to 2/15/48 19..., and that I last saw her alive on 2-15-48 1948 6:25 PM

Immediate cause of death	Duration
Congestive Heart Failure	3 days
Due to Coronary Thrombosis	3 days
Due to Coronary Sclerosis	years
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E J Mendelis M. D.
Address 651 N Bentalou Date signed 2/16/48

VS 150

X

660181

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

660181
Registered No.

GM. 110170 / 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: BALTIMORE CITY HOSPITAL 16-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 months
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 Hoaher (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME IDA BROWN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/23/1887

8. AGE: Years	Months	Days	If less than one day
60	4	16	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Thomas Bolden

13. Birthplace Md

MOTHER 14. Maiden Name Alice Berryman

15 Birthplace Md

16 (a) Informant Records Balto. City Hosp.

(b) Address 4940 Eastern Ave 2-16-48

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem

Location Balto. Md

18 (a) Funeral director Chas. Hooper

(b) Address 512 Carrollton Ave.

19 (a) FEB 16 1948 (Date rec'd by registrar) (b) Signature for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-9 1948, at 9:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19..., to 19..., and that I last saw h... alive on 19...

Immediate cause of death Cerebral accident — Duration 1 day

Due to Generalized Arteriosclerosis

Due to

Other Conditions Old Cerebral accident — 5 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R T Benford M. D.

Address Balto City Hosp Date signed 2-10-48

X

60182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 60182 / 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 26-6
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 dys.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1909 Tennant Way (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George L. Weidman

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-9408

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife R. Olwyn Weidman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24/1918

8. AGE: Years	Months	Days	If less than one day
29	9	21	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Structural Iron Worker
11. Industry or business Arthur Phillips & Co.

FATHER
12. Name William F. Weidman
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Wilhelmina Longley
15. Birthplace Baltimore Md

16 (a) Informant William F. Weidman
(b) Address 2324 Annah Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 17/1948 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director Harry N. Arnavosk
(b) Address 4204 Edgewood Ave

19 (Date rec'd by registrar) FEB 16 1948 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14, 1948 at 2 02 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Fractures Skull, & intra-cranial hemorrhage.

Due to

Other Conditions Multiple fractures, abdominal hemorrhage etc.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 9/2
(a) Date of injury 2/13/48 at 10 04 A.M.
(b) Where did injury occur? Round Hill Tunnel & Nillan Road
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell down shaft

23. Signature Howard J. Weeks M.D. Medical Examiner.
Date signed 2-14-48

VS 151

660183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660183

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address West Baltimore Hospital

(c) Hospital or institution: Rapmor's Dukeland Ave 6-3

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 119 N. patterson Park Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lawrence E. Lauer

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emma A. Lauer 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 20, 1920

8. AGE: Years	Months	Days	If less than one day
27	10	23	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Jr. Mechanic

11. Industry or business

FATHER

12. Name Wm. J. Lauer

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Genevieve Hundemann

15. Birthplace Baltimore Md.

16 (a) Informant Mrs. William J. Lauer

(b) Address 237 N. Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 16 1948 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cemetery

Location 7225 Eastern Ave

18 (a) Funeral director Elmer W. Conklin Son

(b) Address 924 E. Eager St.

19 (a) FEB 16 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/12 1948 at 7:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 1948 to 2/12 1948 and that I last saw h[illegible] alive on 2/12 1948.

Immediate cause of death	Duration
Intracranial Hemorrhage	
Due to Retroperitoneal Hemorrhage	
Due to Hemophilia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Hemorrhage Intracranial Retroperitoneal

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Norman Levin M.D.

Address W B G H Date signed 2/12/48

VS 150

G60184 JL- 117344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G60184

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 752 Waesche St - 1 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lottie Lyles

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1885

8. AGE: Years	Months	Days	If less than one day
63 ?			hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof 2-16-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Walter R. Springs
(b) Address 139 W. Hamburg St.

19 FEB 16 1948 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11 1948, at 12.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1948, to Feb. 11 1948, and that I last saw her alive on Feb. 11 1948.

Immediate cause of death Coronary occlusion, left ventricle — Duration

Due to Arteriosclerosis, gen. coronary.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pt. brain negro cerebral infarction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Vickers M.D.
Address Balto City Hosp. Date signed 13 Feb 48 (M. D.)

VS 150

060185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 60185

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3336 Chestnut Ave
(c) Hospital or institution: 136
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3336 Chestnut Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clifford L Woodside

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-07-2013

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Myrtle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27 1883

8. AGE: Years 64 | Months 4 | Days 18 | If less than one day hr. min.

9. Birthplace Camden N J
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name Ella White
15. Birthplace unknown

16 (a) Informant Myrtle Woodside
(b) Address 3336 Chestnut Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-18-48 (month) (day) (year)

(c) Cemetery or crematory Moreland Mem. Pk
Location Baltimore

18 (a) Funeral director Frank H Seitz
(b) Address 814 N 36th St

19 (a) FEB 16 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15, 1948, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 3 1948 to Feb. 15 1948 and that I last saw him alive on Feb 14, 1948

Immediate cause of death Coronary Thrombosis — Duration

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A Weiss M.D.
Address 2902 Huntingdon Ave Date signed 2-16-48

VS 150

G60186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G60186 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1415 Linden Ave
(c) Hospital or institution: 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sterling Monroe Bankard

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-5946

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Hattie Scott Bankard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17-1875

8. AGE: Years	Months	Days	If less than one day
72	11 10	29	hr. min.

9. Birthplace Mac Windsor
(Town, county, and state)

10. Usual Occupation Laundry Salesman

11. Industry or business

FATHER
12. Name David Bankard
13. Birthplace Carroll Co.

MOTHER
14. Maiden Name Elizabeth - -
15. Birthplace Carroll Co.

16 (a) Informant Hattie S Bankard
(b) Address 1415 Linden Ave Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 18-48 (month) (day) (year)
(c) Cemetery or crematory Westminster Cemetery
Location Carroll Co.

18 (a) Funeral director W. Bankard & Son
(b) Address Westminster, Md

19 (a) FEB 16 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1948, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947 to Feb 16 1948, and that I last saw him alive on Feb 15 1948

Immediate cause of death	Duration
Cardiac Decompensation	40 days
Due to Cardiac Hypertrophy	3 years
Due to General Arteriosclerosis	5 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert F. Stellmann M. D.
Address 6 E Biddle St Date signed 2/16/48

VS 3

G60187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G60187

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 716 GRANTLEY ST.
(c) Hospital or institution: 16-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 716 GRANTLEY ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FLORENCE E McCALL

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM	WHITE	WIDOW

6 (b) Name of husband or wife JOHN A McCALL
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) NOV 22 1878

8. AGE: Years	Months	Days	If less than one day
69	2	23 22	hr. min.

9. Birthplace BALTO MD (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business —

FATHER
12. Name ANDREW WEINKAM.
13. Birthplace BALTO MD

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace NOT KNOWN

16 (a) Informant JOHN H McCALL SR
(b) Address 716 GRANTLEY ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 17-48 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location OLD FREDERICK RD

18 (a) Funeral director Bernard C Hart
(b) Address 131 E West St

19 (a) Date received FEB 16 1948 by Thurlington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1948, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1947 to Feb 14 1948, and that I last saw her alive on Feb 13 1948

Immediate cause of death	Duration
Myocarditis	6 yrs
Due to Cerebral Nephritis	6 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thurlington Williams M.D.
Address 517 Aisquith St Date signed Feb 16 1948

X

C60188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C60188

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17 North Monroe St.
(c) Hospital or institution: ---------- 20-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 17 N. Monroe Street
(If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) **FULL NAME** HARRY D. FORD

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-5675

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Elenor Ford
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) 11 -13- 1881

8. AGE: Years	Months	Days	If less than one day
66	3	**	********** hr. ..... min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Traffic Manager- 40yrs.
11. Industry or business Wm. H. Cole & Sons.

FATHER
12. Name George W. Ford
13. Birthplace Maryland

MOTHER
14. Maiden Name .....Harrison
15. Birthplace Maryland

16 (a) Informant Dallas H. Ford (son)
(b) Address 17 N.Monroe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 16 Feb. 48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn Maryland

18 (a) Funeral director F.B.WIPPERT & SON
(b) Address 1300 EUTAW PLACE....17

FEB 16 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13th 1948, at 7:A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Feb 13 1948 and that I last saw him alive on Feb 13 1948.

Immediate cause of death Coronary Sclerosis & apoplexy - Arteriosclerosis — Duration several years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Byerly M. D.

Address 5033 W. North Ave. Date signed 2/ /48

VS 150

Dr. Paul Byerly X

Dr. Jos. Blum

660189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. 660189

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1212 E. Biddle Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 - 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 E. Biddle Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Rebbert Rhein

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife (Gabriel) Salyer J. Rhein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17, 1872

8. AGE: Years	Months	Days	If less than one day
75	9	30	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Theodore Rebbert
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Fahner
15. Birthplace Baltimore

16 (a) Informant Mr. G. J. Rhein
(b) Address 1212 E. Biddle Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) FEB 16 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16th 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 7, 1947 to Feb. 16 1948, and that I last saw h er alive on Feb. 15 1948.

Immediate cause of death Carcinoma of Stomach & Liver. — Duration 6 mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph S. Blum M. D.
Address 206 E. Preston St. Date signed 2/16/48

VS 150

G60190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. G60190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3310 Batavia Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3310 Batavia Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** William F. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-24-7539

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife Emma D.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4-1870

8. AGE: Years 78 | Months 0 | Days 10 | If less than one day hr. min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation Pensioner

11. Industry or business Md Meter Co.

FATHER
12. Name ✓
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Balto

18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Rd.

19 (a) FEB 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 1948, at 11:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1947, to Feb. 14 1948 and that I last saw him alive on Feb. 12 1948.

Immediate cause of death	Duration
Cardiac decompensation	
Due to Arteriosclerosis C.V. disease	
Due to	
Other Conditions Probable Ca of Pancreas (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Henry Haase, M.D.
Address 4218 Harford Rd. Date signed 2/16/48

VS 153

927

G60191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. G60191

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5907 Kaaon Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5907 Kaaon Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James H. Edgar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife Florence E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 19-1861

8. AGE: Years	Months	Days	If less than one day
86	6	27	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Thomas Edgar
13. Birthplace

MOTHER
14. Maiden Name Susan Harper
15. Birthplace

16 (a) Informant Mrs. Florence Edgar
(b) Address 5907 Kaaon Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-18-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto
18 (a) Funeral director L. J. Luck
(b) Address 6305 Belmont
19 (a) FEB 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15 1948, at 1:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 14 1948, to Feb 15 1948, and that I last saw him alive on Feb 14 1948.

Immediate cause of death: Carcinoma of the Esophagus — Duration 1 yr.
Due to
Due to
Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mary K. English M. D.
Address 5713 Belair Rd. Date signed 2-16-48

VS 150

X

G60193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G60193

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Bon Secour Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2911 Southern Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr ETHORT B. Cox

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife Margaret Eliz.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27-1878

8. AGE: Years	Months	Days	If less than one day
70	0	17	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation B. & O. R.R.

11. Industry or business Supervisor

FATHER 12. Name James R. Cox

13. Birthplace Va.

MOTHER 14. Maiden Name Penelope Dunn

15. Birthplace Va.

16 (a) Informant Mrs. Margaret E. Cox

(b) Address 2911 Southern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/16/48 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Baltimore

18 (a) Funeral director Leonard J. Buck

(b) Address 5305 Harford Road

19 (a) FEB 16 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 19 48, at 11 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 19 48 to Feb 12 19 48 and that I last saw him alive on Feb 12 19 48

Immediate cause of death	Duration
Cardiac failure	
Due to Cardiac infarction	
Due to Degenerative CVD	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. K. Carr M.D.

Address Bon Secour Hosp. Date signed 2-12-48

X

660192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

660192 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison St
(c) Hospital or institution: Cranford Retreat 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4612 Schley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert H. Koegel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Isabel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20-1904

8. AGE: Years	Months	Days	If less than one day
43	7	26	hr. min.

9. Birthplace Baltimore Md. (Town, county and state)

10. Usual Occupation Bookkeeper

11. Industry or business

FATHER
12. Name Peter Koegel
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Bosby
15. Birthplace Germany

16 (a) Informant Mrs. Wm. Koegel
(b) Address 3027 Northway Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Balto

18 (a) Funeral director L. J. Fuck
(b) Address 5305 Harford Rd.

19 (a) FEB 16 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/15 1948, at 1 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to hu death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions Chronic Alcoholism

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury C. LUBINSKI

23. Signature C. J. Lubinski M.D.
Medical Examiner.
Date signed 2/15/48

VS 181

660194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 660194

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1425 N. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY HERZING

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
White	Male	M.

6 (b) Name of husband or wife Frieda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28-1879

8. AGE: Years	Months	Days	If less than one day
69	8	17	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name ✓
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Mrs. John J. Herzing
(b) Address Pasadena, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore

18 (a) Funeral director Leopard & Ruck
(b) Address 5305 Harford Rd.

19 (a) FEB 16 1948 (Date rec'd by registrar) (b) Hunter H. Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14 1948 at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chas. E. Merrill M.D. Medical Examiner.

Date signed 2/14/48

G60195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G60195

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2244 Annapolis Road.
(c) Hospital or institution: W-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2244 Annapolis Road. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) **FULL NAME** John W. ~~Holman~~ Homan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Eva F. Homan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1868

8. AGE: Years	Months	Days	If less than one day
79	4	27	hr. min.

9. Birthplace Atlantic City New Jersey (Town, County, and state)
10. Usual Occupation Glass Worker.
11. Industry or business

FATHER
12. Name Elijah Homan.
13. Birthplace Atlantic City N.J.

MOTHER
14. Maiden Name Clarissa Sutton
15. Birthplace Atlantic City N.J.

16 (a) Informant Mrs. Eva F. Homan
(b) Address 2244 Annapolis Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 17-1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Baltimore Md.

18 (a) Funeral director Mamie Cook Lyffer
(b) Address 1600 W. North Ave Huntington Williams, Md

19 FEB 16 1948 (b) Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Feb. 1948, at 12:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D. Medical Examiner.
Date signed 15 Feb. 48

VS 151

660196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 660196

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 E Lexington Street
(c) Hospital or institution: City Morgue 19-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 411 N. Mount Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia F. Kilbeth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Joseph Kilbeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17. 1889

8. AGE: Years	Months	Days	If less than one day
58	7	28	hr. min.

9. Birthplace Staunton Virginia
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

MOTHER — FATHER

12. Name John Henry Brown
13. Birthplace Staunton Virginia
14. Maiden Name Charlotte Brown
15. Birthplace Staunton

16 (a) Informant Joseph Kilbeth
(b) Address 411 N. Mount Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof February 18, 1948 (month) (day) (year)
(c) Cemetery or crematory Staunton Virginia
Location Augusta County

18 (a) Funeral director Joseph A. Lively
(b) Address 66 West Barre Street

19 (a) Filed Feb 16 1948 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13, 1948 at 2:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection and Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardio-vascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 2/13/48

VS 131

660197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

✓ 660197 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1346 Woodyear ST
(c) Hospital or institution: 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1346 Woodyear ST (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hannah Murray

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widowed

6 (b) Name of husband or wife Mack Murray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
63 62			hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Alexander Murray
(b) Address 1346 Woodyear St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-48 (month) (day) (year)
(c) Cemetery or crematory White Stone Inc
Location

18 (a) Funeral director George S. Nelson
(b) Address 1303 Pressstman ST

19 FEB 16 1948 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1948, at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1947 to Feb 14 1948 and that I last saw h alive on Feb 13 1948

Immediate cause of death Cardiac - Renal — Duration 5 hrs

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. G. Stalcker
Address 1215 Park Ave Date signed 2/15/48

VS 150

X

660198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 M

660198 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Hopkins Hosp.

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 3

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore 17 (If outside city or town limits, write RURAL and give town)

(d) Street No. 1611 Riggs ave (If rural give location)

(e) Citizen of foreign country? ... (Yes or No) If yes, name country

3 (a) FULL NAME Eleanor Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife George Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-24-87

8. AGE: Years	Months	Days	If less than one day
60	5	20	hr. min.

9. Birthplace DC (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Oliver Jones

13. Birthplace Va

MOTHER 14. Maiden Name Oliver Jones

15. Birthplace Va

16 (a) Informant JOHNS HOPKINS HOSPITAL

(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location mch

18 (a) Funeral director George D. Nelson

(b) Address 1303 Presstman St

19 (a) Feb 16 1948 (b) Date received by registrar Lumbering for Williams M.D.

VS 150

MEDICAL CERTIFICATION 35

20. DATE OF DEATH Feb 13 1948, at 11 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 1948, to Feb 13 1948, and that I last saw h.. alive on Feb 13 1948

Immediate cause of death ?G-I malignancy

Due to ?? TBC

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy: given elevation of leg metastasis nodules in lungs, intestinal abscess

Duration
6 mos.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following.

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature David Grob

Address J H H Date signed 2-17-48

X

660199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 660199

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital 27-18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 509 Rossiter Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Oster Seippel (WILLIAM OSTER SEIPPEL)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 220-14-4708

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Elsa Seippel

6 (c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): 3 June 1891

8. AGE: Years 56 | Months 8 | Days 12 | If less than one day: hr. ____ min.

9. Birthplace: Balto., Md.
(Town, county, and state)

10. Usual Occupation: Salesman

11. Industry or business: Warren & Taft

FATHER
12. Name: Rudolph Seippe
13. Birthplace: Baltr. Md.

MOTHER
14. Maiden Name: Emma Gabrio
15. Birthplace: Balto., Md.

16 (a) Informant: Mrs. Elsa Seippel
(b) Address: 509 Rossiter Avenue

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 2/18/48 (month) (day) (year)
(c) Cemetery or crematory: Western Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC
(b) Address: NORTH AVE. & BROADWAY

19 (a) FEB 16 1948 (Date rec'd by registrar) Washington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/15/48 19 , at 1.4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/14 1948 to 2/15 1948, and that I last saw him alive on 2/15 1948.

Immediate cause of death: Cerebral Hemorrhage — **Duration**

Due to Hypertensive vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. Richard Bowen M. D.

Address Union Memorial Hosp. Date signed 2/15/48

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G60200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G60200

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 666- Sarahanne St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY ROBINSON MATTHEWS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife George Matthews
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27, 1891

8. AGE: Years	Months	Days	If less than one day
56	10	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name James Smith
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Rachel Snowden
15. Birthplace St. Thomas Island.

16 (a) Informant Rose Butler
(b) Address 1006 Bennett Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 16 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) FEB 6 1948 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION 11.30

20. DATE OF DEATH Feb. 12, 1948, at p. M

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl Ryan M.D. Medical Examiner.
Date signed 2-13-48

G60201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G60201 Registered No. 93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18-1
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 734 N. Amity Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM CHASE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Bessie Chase

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1887

8. AGE: Years 60 | Months 1 | Days 11 | If less than one day ..... hr. ..... min.

9. Birthplace A. A. County, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Levi Chase
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Chase
15. Birthplace Md.

16 (a) Informant Bessie L. Chase
(b) Address 1236 Division St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 17, 1948 (month) (day) (year)
(c) Cemetery or crematory mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Wolfgang
(b) Address 322 N. Schroeder St.

19 (a) Date rec'd by registrar FEB 19 1948 (b) Registrar Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12, 1948, at 9.25 A M

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH A S C V D

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil Rogy M.D. Medical Examiner.
Date signed 2-13-48

G60202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G60202 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 425 N. Bappleton St
(c) Hospital or institution: 18-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 425 N. Bappleton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arthur Stevens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18, 1887

8. AGE: Years	Months	Days	If less than one day
60	6	24	hr. min.

9. Birthplace S.C. (Town, county, and state)

10. Usual Occupation Construction S.D

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Della White
(b) Address 665 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 16, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/11 1948 at 11:40 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Gulinski M.D. Medical Examiner.
Date signed 2/12/48

VS 151

C60203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131B

C60203

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Redwood & Green

(c) Hospital or institution: Mercy Hospital 16

(d) Length of stay in hospital or inst. (yrs., mos., or days): 11

(e) Length of stay in Baltimore (yrs., mos., or days): —

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md (b) ~~County~~: city

(c) City or town: Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No.: 1405 W. Lanvale St.
(If rural give location)

(e) Citizen of foreign country?: (Yes or No)
If yes, name country:

3 (a) **FULL NAME**: Horace Golphin Or. Harris Golphin

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: M

5. Color or race: B

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Mrs Ruth Golphin

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1902

8. AGE: Years: 46. Months: Days: If less than one day: hr. min.

9. Birthplace: SC
(Town, county, and state)

10. Usual Occupation: Labor

11. Industry or business:

FATHER

12. Name: Allen Golphin

13. Birthplace: S.C.

MOTHER

14. Maiden Name: Ellen Golphin Maiden name not know

15. Birthplace: SC

16 (a) Informant: Mrs Ruth Golphin (Wife)

(b) Address: 1405 W Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb 19 48 (month) (day) (year)

(c) Cemetery or crematory: Augustus Ga

Location:

18 (a) Funeral director: Elroy O Wilson

(b) Address: 1000 Pulaski

19 (a) (Date) (b) Registered by: Huntington Williams, Registrar

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/12 1948, at 9 30 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 2-1 1948 to 2/12 1948, and that I last saw h[illegible] in alive on 2/12 1948.

Immediate cause of death: Uremia

Due to: Respiratory Insufficiency

Due to: Chronic Nephritis

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: 0

Major findings of operation: 0

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury:

23. Signature: R. H. Meyhausen M.D.
M. D.

Address: Mercy Hospital Date signed: 2/12/48

660204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

660204 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 704 N Franklin
(c) Hospital or institution: 17-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 704 N Franklin (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Myrtle Lewis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
51			hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Harris
13. Birthplace Va

MOTHER
14. Maiden Name Myrtle Kinsale
15. Birthplace Va

16 (a) Informant Chas D Lewis
(b) Address 704 W Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/49 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Md

18 (a) Funeral director Isaiah L Brown Sons
(b) Address 1058 W Montgomery St

FEB 16 1949 (Date received by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1949 at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1948 to Feb 12 1949.
and that I last saw her alive on Feb 12 1949.

Immediate cause of death: Carcinoma Head of Pancreas — Duration 9 months
Due to — Duration 9 months
Due to Hypotension
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 10 W Franklin St Date signed 2/14/49

660205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

660205 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1028 Leadenhall St
(c) Hospital or institution: 23-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1028 Leadenhall St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rosa Lee Miller

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/10/1891

8. AGE: Years	Months	Days	If less than one day
57 5/6	-	3	hr. min.

9. Birthplace Manning S C (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charlie Green
13. Birthplace S. C

MOTHER
14. Maiden Name Frizzly Ayer
15. Birthplace S C

16 (a) Informant Amanda Lewis
(b) Address 1028 Leadenhall

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Ct
Location a a. Co., Md

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

(c) FEB 16 1948 (Date rec'd by registrar) (b) Reg. No. 48B

Kunkel for Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13/48 19 at 2:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6/1948 to 2/13/1948, and that I last saw he alive on 2/7/1948.

Immediate cause of death: Carcinoma of Uterus — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. D. Taylor
Address 522 Harlem Ave. Date signed 2/14/48

G60206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G60206 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Catons & Wilkens Aves.
(c) Hospital or institution: St. Agnes Hospital 13-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3510 Chestnut Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Joseph M. Magaha

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lavinia E. Magaha
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1885

8. AGE: Years 62 | Months 11 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Charles Magaha (deceased)
13. Birthplace Md.

MOTHER
14. Maiden Name Kate Heffner (deceased)
15. Birthplace Md.

16 (a) Informant Lavinia E. Magaha
(b) Address 3510 Chestnut Ave.

17 (a) Burial (b) Date thereof Feb 19 1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director [illegible]
(b) Address [illegible]

19 (a) [illegible] (b)
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/15/1948 at 10 15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/13 1948 to 2/15 1948, and that I last saw him alive on 2/15/48 19

Immediate cause of death Congestive heart failure — Duration ?

Due to Coronary heart disease - Repeated

Due to myocardial infarctions

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert J. Lerches

Address St. Agnes Hospital Date signed 2/15/48

VS .150

G60207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G60207

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1214 W. 41st St Dur
(c) Hospital or institution: 13-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 W. 41st St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George F. Martin

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Emma Martin
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Oct 26, 1870
8. AGE: Years: 77 | Months: 3 | Days: 22 | If less than one day: hr. min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Retired Gardener.
11. Industry or business: Govan nursery.

FATHER
12. Name: David W. Martin
13. Birthplace: Maryland.

MOTHER
14. Maiden Name: Mary A. Howard.
15. Birthplace: Maryland.

16 (a) Informant: Mrs. Clara V. Trumblitt.
(b) Address: 1217 W 41st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb 16/48 (month) (day) (year)
(c) Cemetery or crematory: St. Mary's
Location: Hampden.

18 (a) Funeral director: Cranswell & Donovan
(b) Address: 2615-17 Gaither Ave.

19 (a) FEB 16 1948 (Date received by registrar) (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/14 1948, at 4:10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic C.V. disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: C. L. Furbush M.D. (Medical Examiner.)
Date signed: 2/14/48

G60208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 567

G60208 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. & Linden Ave.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Chase
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ebenezer & Harewood Park Roads.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL E FORD

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-10-9427

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Ellice L. Ford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15th, 1901

8. AGE: Years	Months	Days	If less than one day
46	5	-	hr. min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business P.B. & P.R.R.

FATHER
12. Name Sameul G. Ford
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Lela M. McCann
15. Birthplace Harford County, Md.

16 (a) Informant Mrs. S.E. Ford
(b) Address Chase, Md.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 2/19/48 (month) (day) (year)
(c) Cemetery or crematory Poplar Grove Methodist
Location

18 (a) Funeral director Lasseter Funeral Home
(b) Address 7401 Belair Road

19 (a) FEB 16 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Feb 1948, at 7:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8 Feb 1948, to 15 Feb 1948, and that I last saw h[illegible] alive on 15 Feb 1948

Immediate cause of death: Cerebral tumor, left frontal lobe — Duration:
Due to:
Due to:
Other Conditions: Hypertension, cardiorenal disease
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: Tumor left frontal lobe
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Allen Ayres, M.D.
Address [illegible] Date signed 2-16-48

G60209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121B

Registered No. G60209

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3709 Patterson Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Walter J. Ruppert
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Helen M.
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 5/19/88

8. AGE: Years	Months	Days	If less than one day
59	8	25	— hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Executive
11. Industry or business Oil Business

FATHER
12. Name Joseph Ruppert
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elizabeth Brown
15. Birthplace Baltimore

16 (a) Informant Lillian M. Ruppert
(b) Address 3709 Patterson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 18 1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem
Location Pikesville

18 (a) Funeral director John G. Moran
(b) Address 3900 Baltimore St

19 (a) (Date rec'd by registrar) (b) Thos. Williams, M.D. Registrar

FEB 16 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1948, at 9:xx M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/27 1948 to 2/15 1948. and that I last saw him alive on 2/15 1948.

Immediate cause of death	Duration
Respiratory Failure	12 hours
Due to Acidosis	24 hours
Due to Chronic Nephritis	2
Other Conditions Coronary Occlusion	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. D. Ditzpatrick M.D.
Address St. Joseph's Hosp. Date signed 2/16/48 M. D.

660210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

660210 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland North Broadway.

(b) Street address ~~2398 Washington St.~~

(c) Hospital or institution: Church Home & Hosp. 7-1

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 78 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County —

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2395 Washington St

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mr. Andrew Clarke

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs Mary C Clarke

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) Sept 9, 1869

8. AGE: Years	Months	Days	If less than one day
78	5	5	..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Insurance broker

11. Industry or business Insurance broker

FATHER

12. Name Anthony Clark.

13. Birthplace Ireland

MOTHER

14. Maiden Name Bridgett Mulligan

15. Birthplace Ireland

16 (a) Informant Mr Joseph A Clark.

(b) Address 1900 Eutaw Pl, Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 18 1948 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem

Location Old Frederick Road

18 (a) Funeral director John C Mosser

(b) Address 3000 E Baltimore St

19 (a) FEB 2 1948 (Date received by registrar) (b) Thurlow Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1948, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 13 1948, to Feb 14 1948, and that I last saw h— alive on Feb 14 1948.

	Duration
Immediate cause of death Infarction Myocardium due to Arteriosclerotic Coronary thrombosis	15 min
Due to Arteriosclerotic heart disease	15 yrs.
Due to	
Other Conditions Arteriosclerosis general	15 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Arteriosclerosis general.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature David Bodnar M. D.

Address Church Home Hosp Date signed 2/14/48

X

G60211 ✓ G60211

AB-79787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 110 B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 1-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 505 S. Curley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Mulligan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept-6- 1868

8. AGE: Years 79 | Months 5 | Days 8 | If less than one day ..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Old Age Pension

11. Industry or business

FATHER
12. Name Frederick Mulligan
13. Birthplace ?

MOTHER
14. Maiden Name Catherine ?
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/48 (day) (year)
(c) Cemetery or crematory New Cathedral Rd.
Location Old Baltimore

18 (a) Funeral director Thos. J. Mahoney
(b) Address 300 E. Balto St.

19 (a) (Date received by registrar) (b) Thos. Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 1948, at 8.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-12- 1943, to 2-14- 1948 and that I last saw her alive on 2-14- 1948.

Immediate cause of death: Bronchopneumonia — Duration

Due to:

Due to:

Other Conditions: adhesive pleurisy R LL; Pulm. Congestion L LL

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Generalized arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. T. Bamford M. D.
Address Balt. City Hosp. Date signed 2-15-48

150

107

G60212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127a

G60212 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St

(c) Hospital or institution: So. Balti. Gen. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12da

(e) Length of stay in Baltimore (yrs., mos., or days) 63yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 302 Jeffrey St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Margaret C Webster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Alfred F Webster

6 (c) If alive, give age years

7. Birth date of deceased (mo.) Oct (day) 12 1885

8. AGE: Years 63 Months 4 Days 3 If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, State)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Adam Vogel

13. Birthplace Germany

MOTHER

14. Maiden Name Anna Barbara

15. Birthplace Germany

16 (a) Informant Mr Alfred Webster

(b) Address 302 Jeffrey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 (month) 18 (day) 48 (year)

(c) Cemetery or crematory Loudon Hill Cem

Location Cor Ritchie Highway

18 (a) Funeral director Milton Schilling

(b) Address 3914 Hanover St

19 (a) FEB 16 1948 (Date rec'd by registrar) (b) Registrar Washington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 (month) 15 (day) 19 48 (year) 1:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/3 1948 to 2/15 1948 and that I last saw h[illegible] alive on 2/15 1948.

	Duration
Immediate cause of death: Acute myocardial infarction of pulmonary embolus	10 min.
Due to Pontage. 12da.	
Due to Empyema Gall bladder	
Other Conditions Arterio Sclerotic heart disease. (Include pregnancy within 3 months of death)	

Date of operation 2/3/48

Major findings of operation: Empyema of gall bladder

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H D Cooper M.D.

Address 1213 Light St. Date signed 2/15/48

VS 150

C60213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

C60213 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2627 St Paul St
(c) Hospital or institution: 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2627 St Paul St 18
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) **FULL NAME** William J. Campbell Jr

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of ~~husband~~ or wife Mollie T. Campbell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22-1866

8. AGE: Years	Months	Days	If less than one day
81	7 -	-22	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Retired Bookkeeper
11. Industry or business

FATHER
12. Name William J. Campbell Sr
13. Birthplace England

MOTHER
14. Maiden Name M. Logan
15. Birthplace England

16 (a) Informant Lelia Tillard
(b) Address 2627 St Paul St

17 (a) Burial (Burial, cremation, or Removal) (b) Date thereof 2/17/48 (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location Frederick Rd

18 (a) Funeral director Milton Schilling
(b) Address 3914 Hanover St

19 (a) (b)
(Date rec'd by registrar) Huntington Williams Registrar

FEB 16 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15 1948, at 1.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1947, to Feb 15 1948, and that I last saw ~~him~~ alive on Feb 15 1948.

Immediate cause of death: Coronary Artery Disease — Duration 4½ mos
Due to Senility — —
Due to Prostatism — —
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lemuel Lockard M. D.
2425 N. Charles St. Date signed 2-25-47

C60214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8 3a

C60214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Green & Lombard

(c) Hospital or institution: Univ. Hospital 12

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2007 Guilford Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lawrence Markland

3 (b) If veteran, name war: World War #1. — 3 (c) Social Security Account No.

4. Sex: Male — 5. Color or race: White — 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Ruth Markland — 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 65 — Months — — Days — — If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Printer

11. Industry or business

FATHER

12. Name Thomas A. Markland

13. Birthplace Md.

MOTHER

14. Maiden Name Hanna C. Mowbray

15. Birthplace Cambridge Md.

16 (a) Informant Mr. Thomas Markland

(b) Address 2007 Guilford Ave.

17 (a) Burial — (Burial, cremation, or removal) (b) Date thereof 2-17-48 (month) (day) (year)

(c) Cemetery or crematory National — Balto. City Location

18 (a) Funeral director Wiedefeld & Son

(b) Address Greenmount & 22nd Sts.

19 (a) FEB 16 1948 (Date received by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-13 1948, at 8:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-7 1948 to 2-13 1948 and that I last saw him alive on 2-13 1948.

Immediate cause of death: Cardiac failure

Due to: Cerebral vascular accident

Due to: hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Howard E. Hall M. D.

Address Date signed

X

G60215 ✓ G60215

BALTIMORE CITY HEALTH DEPARTMENT

G60215 **CERTIFICATE OF DEATH** 93c Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2028 W. Fayette St
(c) Hospital or institution: Bon Secours Hosp 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town Baltimore — 15
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2530 Oswego Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Virginia Lee Konitzer ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Mr William Joseph Konitzer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1919

8. AGE: Years	Months	Days	If less than one day
29			hr. min.

9. Birthplace MD (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name CHAS. W. MILLER
13. Birthplace BALTO., MD.

MOTHER
14. Maiden Name LEONA RALPH
15. Birthplace MD.

16 (a) Informant MR. WM. JOS. KONITZER
(b) Address 2530 OSWEGO AVE.

17 (a) BURIAL - (b) Date thereof 2-16-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL CEM.
Location CITY -

18 (a) Funeral director WIEDEFELD & SON
(b) Address BELMONT & 22 ND ST.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-13 1948, at 11 34 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-30 1948 to 2-13 1948.
and that I last saw h e r alive on 2-13 1948.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Infarcts Both Extremities	
Due to Rheumatic C.V.D.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George W. Fetter M.D.
Address Bon Secours Hosp Date signed 2-15-48

X

660216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

Registered No. 660216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 7-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 707 N. Collington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH D. BENEDICT

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillian M. Benedict

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct 11, 1908

8. AGE: Years: 39 | Months: 4 | Days: 2 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Police

11. Industry or business:

FATHER
12. Name: John Benedict
13. Birthplace: Bohemia

MOTHER
14. Maiden Name: Elizabeth Ella
15. Birthplace: Bohemia

16 (a) Informant: Lillian Benedict
(b) Address: 707 N. Collington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2-17-48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Baltimore Md

18 (a) Funeral director: Frank Brockman
(b) Address: 900 W. Chester St

19 (a) FEB 16 1948 (Date rec'd by registrar) (b) Registrar: Huntington Williams, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13, 1948, at 4:25 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Bullet wound of Heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-13-48 at about 4 a. M. 33rd & Lochraven Blvd.
(b) Where did injury occur? Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Firearms

23. Signature: Earl L. Royer M.D. Medical Examiner
Date signed 2-13-48

X

660217 EMMA ✓ 660217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2506 Arbuton Ave
(c) Hospital or institution: 25-✓
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2506 Arbuton Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Emma louise Lloyd

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Harrison Lloyd
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Sept-1-1890

8. AGE: Years 57 | Months 5 | Days 12 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name John Decker
13. Birthplace Germany

MOTHER
14. Maiden Name Ellen Priscilla ?
15. Birthplace Germany.

16 (a) Informant Mr Harrison Lloyd
(b) Address 2506 Arbuton Ave.

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 2 / 17 / 48 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge Mem Pk
Location Dorsey Md.

18 (a) Funeral director John J. Curran & Son
(b) Address 2603 Hollins St.

19 (d) FEB 16 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February -13- 1948, at 6 25 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1946 to 2-13- 1948, and that I last saw h.. alive on 2-13- 1948.

Immediate cause of death: Acute heart failure
Due to: Coronary occlusion
Due to: Coronary sclerosis and cardio-vascular disease
Other Conditions: Arteritis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: about 2 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter H. Sonnenfeldt M. D.
Address 2708 Hollins Ferry Rd Date signed 2/18/48

VS 150

X

660218 BALTIMORE CITY HEALTH DEPARTMENT 660618
CERTIFICATE OF DEATH 94a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3208 Clifton Ave.,
(c) Hospital or institution: 15-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3208 Clifton Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph David Biden

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mabel Biden

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1872

8. AGE: Years 76 | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace Md.

10. Usual Occupation Retired Chief Clerk (Trade, profession, or particular kind of work)

11. Industry or business Electrical Dept. B. & O. R. R.

FATHER
12. Name James Biden
13. Birthplace Md.

MOTHER
14. Maiden Name Jane E. Elkins
15. Birthplace Charlestown, W. Va.

16 (a) Informant Mrs. Mabel Biden
(b) Address 3208 Clifton Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director J. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) FEB 16 1948 (Date Rec'd by Registrar) (b) Huntington Wills, Registrar

MEDICAL CERTIFICATION 6.30

20. DATE OF DEATH February 13 1948, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 13 1948, to Feb. 13 1948, and that I last saw alive on Feb. 13 1948.

Immediate cause of death — Duration

Coronary occlusion — 2 hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Kenneth A. Kelley, M. D.
Address 3207 St. Paul St. Date signed 2/14/48

VS 150

660219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660219 124B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 522 South Washington St.
(c) Hospital or institution: 1-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2235 Gough St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Foster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife. Frank Foster

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 51 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Vincent Kabat
13. Birthplace Poland

MOTHER
14. Maiden Name Rose Thomas
15. Birthplace Poland

16 (a) Informant Miss Helen Kabat (sister)
(b) Address 522 S. Washington street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) FEB 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-12-1948 at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy & Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial degeneration

Due to

Other Conditions Fatty degeneration of liver (Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Snyder M.D. Medical Examiner.
Date signed 2-13-48

VS 191

937

660220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 660220

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1947 Perlman Place.
(c) Hospital or institution: 8-V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1947 Perlman Place.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY BRUINS.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 48 | Months | Days | If less than one day hr. min.

9. Birthplace Holland
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Western Electric

FATHER
12. Name —
13. Birthplace Holland

MOTHER
14. Maiden Name —
15. Birthplace Holland

16 (a) Informant Mrs. Florence Bruin
(b) Address 1947 Perlman Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Meadow Ridge
Location Dorsey Md.

18 (a) Funeral director Leo F. Leach
(b) Address 1701-03 N. Patterson Park Ave

19 (a) FEB 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15, 1948, at 8.45 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl N. Royer M.D.
Medical Examiner

Date signed 2-16-48

X

G60221

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

G60221
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Dr. & 31st St.
(c) Hospital or institution: U. S. Marine Hospital 27-18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2:45 hrs 0 days
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5107 Cardelia Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Harry George McCleary

3 (b) If veteran, name war: Spanish-American War
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Div.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 12, ~~1861~~ 1877

8. AGE: Years	Months	Days	If less than one day
70 ~~60~~	3	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

MOTHER FATHER
12. Name ?
13. Birthplace Md.
14. Maiden Name ?
15. Birthplace Md.

16 (a) Informant Hospital records.
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 17th 1948 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto National
Location Frederick Road

18 (a) Funeral director Lee G. Leach
(b) Address 1701-03 N. Patterson Park Ave

19 (a) FEB 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15 1948, at 1:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 14 1948 to Feb. 15 1948, and that I last saw him alive on Feb. 15 1948

Immediate cause of death	Duration
Cerebral hemorrhage, massive, bilateral	Several hrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 2/16/48

(150222)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. 650222

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST
(c) Hospital or institution: St. Joseph's Hosp. 7-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 702 N. Curley St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ANTON Hejduk

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-16-2457

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of ~~husband~~ or wife Frances (nee Holin)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/17/77

8. AGE: Years	Months	Days	If less than one day
70	7	26	hr. min.

9. Birthplace EUROPE (Town, county, and state)
10. Usual Occupation Printer
11. Industry or business A. Hoen Co.

FATHER
12. Name unknown
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Anna Matura
15. Birthplace Czechoslovakia

16 (a) Informant Mrs. Ella Annello - daughter
(b) Address 702 N. Curley Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/48 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-3-5 E. Madison Street

19 (a) Filed FEB 16 1948 (Date) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Feb 1948, at 12-45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-29-1948 to 2-13-1948, and that I last saw h~~e~~ alive on 13 Feb 1948

Immediate cause of death	Duration
Cardio Resp. failure	
Due to Carcinomatosis	
Due to Carcinoma of esophagus	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2-3-48
Major findings of operation: Carcinoma of esophagus & metastasis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas A. Bosnian M. D.
Address St. Joseph's Hosp Date signed 2/13/48

X

660223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered 660223

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley La. 10-1
(c) Hospital or institution: Home for the Aged Town
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia Rode

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	W.

6 (b) Name of husband or wife — Rode
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1869

8. AGE: Years	Months	Days	If less than one day
78 77	3	19	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Peter Dunn
13. Birthplace

MOTHER
14. Maiden Name Cath. Kelly
15. Birthplace

16 (a) Informant Lillie Linton Daughter
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 18, 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St

19 (a) FEB 16 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15 1948, at 10:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1948 to Feb 12 1948, and that I last saw h er alive on Feb 14 1948.

Immediate cause of death	Duration
Edema Lungs	10 days
Due to	
Due to Chronic Myocarditis	2 yrs
Other Conditions	5 yrs
Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Bill Hall M. D.
Address 1631 E. North Ave Date signed 2/16/48

VS 150

X

660224 F 44624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 660224

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 26-1
(c) Hospital or institution: Maryland Sail Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4607 Glenarm Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Vaeth

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	None	M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 18-1942

8. AGE: Years	Months	Days	If less than one day
5	11	27	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation
11. Industry or business At School

FATHER
12. Name Harold A. Vaeth
13. Birthplace Balto.

MOTHER
14. Maiden Name Margaret E. Amerman
15. Birthplace Balto.

16 (a) Informant Harold A. Vaeth
(b) Address 4607 Glenarm Ave

17 (a) Burial Borsa (Burial, cremation, or removal) (b) Date thereof 2 17 48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd

18 (a) Funeral director Dippel Bros
(b) Address 4300 Belair Rd

19 (a) FEB 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Feb 1948, at 12:31 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11 Feb 48 at 9:00 A.M. 11/4
(b) Where did injury occur? 1201 N. Eutaw St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Hit or upset by fall on school ground

23. Signature Carl Voegtlen M.D. Medical Examiner.
Date signed 15 Feb 48

G60225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G60225

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Eutaw & Wilkens Aves.
(c) Hospital or institution: Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3½ yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Annapolis, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Sarah Anna Denver

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/13/1870

8. AGE: Years	Months	Days	If less than one day
77	2	3	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER
12. Name Andrew Durand E. Denver
13. Birthplace Md

MOTHER
14. Maiden Name Marian Durand a Kramer
15. Birthplace Md

16 (a) Informant John M. Taylor
(b) Address Annapolis Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 18, 1948 (month) (day) (year)

(c) Cemetery or crematory St. Mary's Cemetery
Location Annapolis, Md.

18 (a) Funeral director Chas Lamotrat
(b) Address 1003 N. Baltimore St

19 (a) Feb 16 1948 (b) Huntington Hilligues, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/16 1948, at 8 05 A.M.

21. I certify that death occured on the date above stated; that I attended deceased from 9/6 1944 to 2/16 1948, and that I last saw her alive on 2/16 1948.

Immediate cause of death	Duration
Coronary thrombosis	
Due to Arteriosclerotic hypertensive cardiovascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: —

of autopsy: none performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hubert J. Lovelace
Address St Agnes Hosp Date signed 2/18/48

660226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 660226

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2724 MARYLAND AVE
(c) Hospital or institution: NONE 12-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) NONE
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY (If outside city or town limits, write RURAL and give town)
(d) Street No. 2724 MARYLAND AVE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT SIDNEY STARLINGS, M.D.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Married

6 (b) Name of husband or wife Florence T. Toner Starlings
6 (c) If alive, give age 66 years
7. Birth date of deceased (mo., day, yr.) Aug. 10, 1878

8. AGE: Years	Months	Days	If less than one day
69	6	4	hr. min.

9. Birthplace Anne Arundel Co. Md. (Town, county, and state)
10. Usual Occupation Physician and Teacher
11. Industry or business

FATHER
12. Name Albert Knox Starlings
13. Birthplace Anne Arundel Co. Md.

MOTHER
14. Maiden Name Helen Nutwell
15. Birthplace Anne Arundel Co. Md.

16 (a) Informant Mrs. Florence Toner Starlings
(b) Address 2724 Maryland ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Chas. J. Evans & Son, Inc.
(b) Address 6 W. Mt. Royal Ave

19 (a) FEB 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 14 1948 at 5. P M

21. I certify that death occurred on the date above stated; that I attended deceased from DEC 1 1947 to FEB 14 1948.
and that I last saw him alive on FEBY. 14 1948

Immediate cause of death	Duration
CHRONIC MYOCARDITIS DEC 1	1947
Due to ARTERIOR SCLEROSIS.	1947
Due to	
Other Conditions PROSTECTOMY	1945.

(Include pregnancy within 3 months of death)
Date of operation SEPTEMBER 8 1945
Major findings of operation: BENIGN TUMOR.
of autopsy: NONE

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert S. Starlings
Address 3013 ST PAUL STREET Date signed FEBRUARY 14 1948

X

G60227 ✓ G60227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

837 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution South Balto Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2427 Lakeview ave
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME George T Smith

3 (b) If veteran, name war ----

3 (c) Social Security Account No. ------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	married

6 (b) Name of husband or wife Idell M. Davidson Smith
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) July 4, 1882

8. AGE: Years	Months	Days	If less than one day
65	7	9	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Balto. Fire Dept.

FATHER
12. Name James Newton Smith
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Margaret N. Boland
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Idell Davidson Smith
(b) Address 2427 Lakeview ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans & Son Inc
(b) Address 118 N. Mt. Royal Ave

19 (a) FEB 16 1948 (Date rec'd by registrar) (b) Huntington Woods, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13 1948 at 5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19__ to 2/13 1948.
and that I last saw h alive on 2/13 1948.

Immediate cause of death	Duration
Uremia	
Due to Paraplegia	25 yrs
Due to Fracture of back	2 mos
Other Conditions Diabetes mellitus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H D Cooper M.D.
Address 1213 Light St. Date signed 2/15

VS 150

660228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 660228

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1214 Bayard St, 21-2
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 Bayard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eunice Marie Wallace.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	single

6 (b) Name of husband or wife ~

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-16-1909

8. AGE: Years	Months	Days	If less than one day
38	1	27	hr. min.

9. Birthplace A. A. County, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Albert Wallace.
13. Birthplace A. A. County Md.

MOTHER
14. Maiden Name Isabell Wallace
15. Birthplace 1214 Bayard St.

16 (a) Informant Isabella Wallace
(b) Address A. A. County Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 16, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Willis
(b) Address 322 N. Schroeder St

19 (a) Feb 16 1948 (Do not write day and hour) (b) Filed [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1948, at 5.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1948 to Feb 12 1948 and that I last saw her alive on Feb 12 1948

Immediate cause of death	Duration
Pulmonary Edema	Sudden
Due to Bronchial Asthma	4 yrs
Due to Coronary Artery Disease	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John C. Ulmer Jr
Address 1222 Druid Blvd Date signed 2/14/48

VS 150

X

060229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registered No. 060229

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [illegible]
(c) Hospital or institution: Sydenham Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9days
(e) Length of stay in Baltimore (yrs., mos., or days) 18yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3037 Harlem ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mary Anita Sybert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/12/29

8. AGE: Years	Months	Days	If less than one day: hr.	min.
18	6	3		

9. Birthplace Baltimore, Md. (City) (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Ralph Johns Sybert
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Ada Durbaise
15. Birthplace Baltimore

16 (a) Informant Mother
(b) Address 3037 Harlem Ave-Balt 16

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2. 17. 48 (month) (day) (year)
(c) Cemetery or crematory Mem Cathedral
Location 3900 old Frederick Rd

18 (a) Funeral director Harry A. Welsh Jr
(b) Address 401 Edmondson Ave

19 (a) FEB 16 1948 (To be filled in by registrar) (b) Lintington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/15 1948, at 12:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6 1948 to 2/15 1948, and that I last saw her alive on 2/15 1948.

Immediate cause of death	Duration
Respiratory failure	
Due to Pneumonia	1 day
Due to Acute Dilatation of heart	5 wks.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Margaret M. Hammond M.D.
Address Sydenham Hosp. Date signed 2/15/48

V S 150

G60230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

G60230 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 425 Wingate Road.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs.

27-14

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 425 Wingate Road. (If rural give location)
(e) Citizen of foreign country? Md (Yes or No)
If yes, name country

3 (a) FULL NAME Emma King Oggesen

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: widowed.
6 (b) Name of husband or wife: John O. ~~H~~ Oggesen
6 (c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.) Apr 5 - 1869
8. AGE: Years 78 | Months 10 | Days 15/30 | If less than one day ____ hr. ____ min.
9. Birthplace Pleasantville, Conn. (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business —

FATHER
12. Name Charles King
13. Birthplace Germany.

MOTHER
14. Maiden Name Catherine Werking
15. Birthplace Germany.

16 (a) Informant Mrs. L. Oggesen
(b) Address 425 Wingate Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof ____ (month) ____ (day) ____ (year)
(c) Cemetery or crematory Evergreen Cem. New Haven Connecticut
Undertaker D.C. Miller
18 (a) Funeral director Hayley W. Lincoln
(b) Address 93 W Whitney Ave New Haven Conn.
19 (a) ____ (Date received by Registrar) (b) ____ Registrar

FEB 16 1948

Huntington Williams, M.D.

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1948, at 10 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1947 to Feb 15 1948.
and that I last saw her alive on Feb 15 1948.

	Duration
Immediate cause of death: Cardiac decompensation	4 hrs
Due to: Aortic stenosis	8 yrs.
Due to: Cardio-vascular disease	13 yrs.
Other Conditions: —	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frederick Wm. Oggesen M.D.
Address 446 W 36 St - Date signed 2/16/48

660231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54a

Registered No. 660231

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Peru (b) County S. America
(c) City or town Lima
(If outside city or town limits, write RURAL and give town)
(d) Street No. San Isidro
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country S. America

3 (a) FULL NAME Maria Barrios

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Oscar

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-14-12

8. AGE: Years 35 | Months 1 | Days 28 | If less than one day hr. min.

9. Birthplace South America
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edward Pernand
13. Birthplace France

MOTHER 14. Maiden Name Delia Giuffre
15. Birthplace Peru

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) removal (b) Date thereof 2/16/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Washington, D.C.
Location

18 (a) Funeral director T. F. Costello
(b) Address 1722-N. Capt. St. West D.C.
(c) (Date rec'd by registrar) (d) Arrington Williams, Registrar

FEB 16 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1948 to Feb 16 1948, and that I last saw h[illegible] alive on Feb 16 1948.

Immediate cause of death: Pneumonia, Left Lower Lobe — Duration: 3 days

Due to: Medulla Oblongata, cerebellum — 3 months

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation Dec 24, 1947

Major findings of operation: medulla oblongata & cerebellum

of autopsy: Medullary tumor

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E. Yee M.D.
Address Johns Hopkins Hosp. Date signed 2/16/48

X

G60232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G60232

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1807 Rutland Avenue
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 Rutland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie E. Merriken

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Francis M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1864

8. AGE: Years 83 | Months 4 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace: Baltimore County, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Sapp
13. Birthplace: Baltimore County, Md.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant: Robert Merriken
(b) Address: 1807 Rutland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 19-48 (month) (day) (year)
(c) Cemetery or crematory: Cemetery- Oaklawn
Location: Baltimore County, Md.

18 (a) Funeral director: Wm. Cook, Inc.
(b) Address: 1217 St. Paul Street

19 (a) FEB 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 190

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH Feb. 15 1948, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1947, to Feb 15 1948, and that I last saw her alive on Feb 14 1948.

Immediate cause of death	Duration
Myocarditis	
Due to	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lucat Fuselier M. D.

Address 1823 N Mont. St. Date signed 2/16/48

X

G60233

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. G60233

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution: Edgewood Nursing Home 9-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) /
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 Parkwerth Ave. (If rural give location) Parkwyrth
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth F. Claypoole

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife James Y.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8 / 1883

8. AGE: Years	Months	Days	If less than one day
64	2	6	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Howard Miles
13. Birthplace Maryland

MOTHER
14. Maiden Name Barbara Spencer
15. Birthplace Maryland

16 (a) Informant James Y. Claypoole
(b) Address 615 Parkwerth Ave.

17 (a) Gevans Presbyterian (Burial, ~~cremation, or removal~~) (b) Date thereof 2/17/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~
Location Baltimore, Maryland

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul Street

19 FEB 17 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17 1948 at 5 p.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from February 1948 to Feb. 17 1948 and that I last saw h[illegible] alive on Feb. 14 1948.

Immediate cause of death Coronary Thrombosis
Heart-Failure
Due to Myocardial degeneration of Heart-Muscle.
Due to
Other Conditions Diabetes (mellitus)
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
unknown

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mark Tranyott M.D.
Address 1623 E. N. Ave. Date signed 2/16/48

VS 150

93D

G60234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G60234

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital W. 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Krause Hotel- 419 W. Camden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES A. WESLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) April 26th 1890

8. AGE: Years	Months	Days	If less than one day
57	9	19	____ hr. ____ min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Anton Wesley
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Edward Meyer
(b) Address 5618 Ready Ave.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/18/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) FEB 17 1948 (Date rec'd by registrar) (b) Huntington-Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15, 1948, at 7.15p M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl Kaplan M.D. (Medical Examiner)

Date signed 2-16-48

VS 151

X

660235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 660235

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 2-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 224 S. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME VERNON DUCKWORTH

3 (b) If veteran, name war

3 (c) Social Security Account No. 200-91-812

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Separated

6 (b) Name of ~~husband or~~ wife: Beatrice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 9th 1912

8. AGE: Years 35 | Months 9 | Days 4 | If less than one day: hr. min.

9. Birthplace: Frostburg Md. (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business: Weis Kitel

FATHER
12. Name: Samuel T. Duckworth
13. Birthplace: Md.

MOTHER
14. Maiden Name: Libby Miller
15. Birthplace: Md.

16 (a) Informant: Fred Duckworth
(b) Address: 143 S. Calverton Rd.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/18/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~: Cedar Hill
Location: a. a. Co. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.

FEB 17 1948 (Date rec'd by registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13, 1948, at 12.45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Lobar pneumonia

Due to:

Other Conditions: Rheum. heart, pregnancy

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 2-12-48 at ? M.
(b) Where did injury occur? Found Camden St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Ingestion phenobarb.

23. Signature: Carl Kyle M.D. (Medical Examiner)
Date signed 2-14-48

VS 191

660236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

102

660236
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2748 Fenwick Ave
(c) Hospital or institution: 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2748 Fenwick Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Bowman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. ~~Sex~~ Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife William N. Bowman

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1890

8. AGE: Years 57 | Months 3 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Frank C. Long
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary F. Myers
15. Birthplace Md

16 (a) Informant William N. Bowman
(b) Address 2748 Fenwick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 18-1948 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn Md

18 (a) Funeral director Mr. Mrs. John W. Tankersley
(b) Address 5311 Edmondson Ave

19 (a) FEB 17 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1948, at 2:10 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to Feb 1948 and that I last saw h e alive on Feb 15 1948.

Immediate cause of death Essential hypertension — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William L. Helfrich

Address 5006 Roland Ave Date signed 2/16/48

VS 150

G60237

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 13a

Registered No. G60237

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 521 Bloom St

(c) Hospital or institution: 14.3

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 521 Bloom St (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH ALSTON

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Carrie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/2/1864

8. AGE: Years	Months	Days	If less than one day
83	8	11	hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Dennis Alston

FATHER 13. Birthplace N.C.

MOTHER 14. Maiden Name Sarah

MOTHER 15. Birthplace N.C.

16. (a) Informant Carrie Alston (W)

(b) Address 521 Bloom St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/48 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem'l. Pk.

Location Balto. County Md

18 (a) Funeral director Charles G. Cooper

(b) Address 512 Carrollton Ave

FEB 17 1948 (b) Huntington Williams, M.D. Registrar

(Date rec'd by Registrar)

VS 150 4-18

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13/48 19 , at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/9 19 48 to 2/13 19 48.

and that I last saw h alive on 2/10 19 48.

Immediate cause of death Cardio-Renal-Vascular Disease — Duration 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Dennis Alston

Address 522 a Carrollton Ave Date signed 2/16/48 M.D.

X

G60238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G60238

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17-1
(c) Hospital or institution: Univ. Hosp DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 403 N Fern St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Vince - Vince

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-9458

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 53 | Months | Days | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Trust Comm. helper

11. Industry or business

FATHER
12. Name Joseph Vince
13. Birthplace Italy

MOTHER
14. Maiden Name Dora Stonino
15. Birthplace Italy

16 (a) Informant Mrs Nellie Pusinsky
(b) Address 536 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 18 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Old Frederick Rd

18 (a) Funeral director Joseph Farace Inc
(b) Address 201 E Lexington St

FEB 17 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1948, at 9:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an ~~external cause~~ was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kelbaugh M.D. Medical Examiner.
Date signed 2/15/48

VS 181

G60239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G60239
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3908 Ridgecroft Rd.
(c) Hospital or institution: 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 Ridgecroft Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES M. ROCK SR.

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Esther E. Rock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 25, 1883

8. AGE: Years	Months	Days	If less than one day
64	9	19	hr. min.

9. Birthplace Sharps, Va.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Thomas H. Rock
13. Birthplace Va.

MOTHER
14. Maiden Name Mollie Hinstead
15. Birthplace Va.

16 (a) Informant Mrs. Esther E. Rock
(b) Address 3908 Ridgecroft Rd.

17 (a) Burial (b) Date thereof 2/17/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Moreland Mem. Park
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves., Balto. 17, Md.

19 (a) FEB 17 1948 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14, 1948, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1944, to 2/14 1948 and that I last saw h~~im~~er alive on 2/13 1948.

Immediate cause of death	Duration
Coronary Occlus.	1 hr.
Due to Ch. Myocarditis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J S Hardesty M. D.
Address 380 S Belnord Ave Date signed 2/16/48.

X

660240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

660240 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 16-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1422 Poplar Grove ST (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Ethel M. Deitsch

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	MARRIED

6 (b) Name of husband or wife EDWARD N.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-16-16

8. AGE: Years	Months	Days	If less than one day
31	6	0	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business —

FATHER
12. Name Robert Bennett
13. Birthplace Md

MOTHER
14. Maiden Name Lillian Taylor
15. Birthplace Md.

16 (a) Informant Mrs. Edward N. Deitsch
(b) Address 1422 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Baltimore Md

19 (a) 2-18-1948 (Date rec'd by registrar) (b) Huntingtor Williams, M.D. Registrar

MEDICAL CERTIFICATION 35 A

20. DATE OF DEATH Feb. 16 1948, at 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-24- 1948 to Feb 16 1948, and that I last saw her alive on Feb 16 1948.

Immediate cause of death	Duration
Uraemia	
Due to Carcinomatosis peritonei	
Due to [illegible]	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 12-9-47
Major findings of operation: — above —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ellen C. Rice M. D.
Address Johns Hopkins Hosp Date signed 2-16-48

X

VSR 150 A 1948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660241

660241

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians—please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1708 Eutaw Place

(c) Hospital or institution: Elm Hurst Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Riderwood Md
(If outside city or town limits, write RURAL and give town)

(d) Street No. Stevens Hill Rd
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Newton STREWIG Strewig.

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 6 1868

8. AGE: Years	Months	Days	If less than one day
79	2	12	hr. min.

9. Birthplace Ursuline Mills, Balto. Md.
(Town, county, and state)

10. Usual Occupation Motorman

11. Industry or business Balto. Transit

FATHER 12. Name Noah Strewig

13. Birthplace Dover Europe

MOTHER 14. Maiden Name Ellen Bailey

15. Birthplace Balto. County

16 (a) Informant Darrell Strewig

(b) Address Ursuline Mills, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 18 1948 (month) (day) (year)

(c) Cemetery or crematory Reisterstown Methodist

Location Reisterstown, Md.

18 (a) Funeral director Wm. Berrymount Sons

(b) Address Reisterstown, Md.

19 FEB 17 1948 (Date received by Registrar) (b) Huntington Nottingham M.D. Registrar

V5 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1948, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 25 1948, to Feb. 15 1948, and that I last saw h.i.m alive on Feb. 15 1948

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Adv. arteriosclerosis

Due to

Other Conditions Starvation & Exposure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Louis J Garol M. D.

Address 1700 Eutaw Pl. Date signed Feb. 16-1948

X

660242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. 660242

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 7-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 N. Chester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME PETER PAUL MIERZEJEWSKI (Mezewski)

3 (b) If veteran, name war

3 (c) Social Security Account No 219-01-3212

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893?

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name UNKNOWN

13. Birthplace "

MOTHER 14. Maiden Name "

15. Birthplace "

16 (a) Informant Mrs Eva Winkler Sister

(b) Address 516 N. Chester st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-18-48 (month) (day) (year)

(c) Cemetery Holy Rosary

Location Balto. co, Md

18 (a) Funeral director Graze & Weber

(b) Address 705 S Pine st

19 FEB 17 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15, 1948, at 8 p. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute Alcoholism

Due to

Other Conditions Hypertrophy; acute Dilatation of the heart. Acute Pulmonary Edema. (Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Madeira M.D. Medical Examiner.

Date signed 2-16-48

VS 191

77c

650243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12/a

Registered No. 650243

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 22-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) remains
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2421 W. Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mickey Urman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
65 ?			hr. min.

9. Birthplace Lithuanian (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name ? Urman
13. Birthplace Lithuanian

MOTHER
14. Maiden Name Not known
15. Birthplace Lithuanian

16 (a) Informant Mr. Joseph Paulonis
(b) Address 409 W. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 16-48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location German Hill Road

18 (a) Funeral director John J. Grefrianz
(b) Address 423 S. Paca St

19 (a) FEB 17 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/15 1948, at 1:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic - Cardio - Renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
Did injury occur at home, on farm, industrial place, in public place? While at work?
(c) Nature of injury

23. Signature D. J. Labrinka M.D.
Medical Examiner.
Date signed 2/15/48

VS 191

X

660244 JL - 117428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660244

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. If correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City HOspitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 Appleton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clark Newton

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-20-7388

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1902

8. AGE: Years	Months	Days	If less than one day
45	8	12	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name Richard Newton
13. Birthplace N. J.

MOTHER
14. Maiden Name Annie ? Gray
15. Birthplace ? Balto Md

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Cem
Location Baltimore Md

18 (a) Funeral director Geo. T. J. Gibson
(b) Address 1350 Wm. Fitzsimmons

19 (a) FEB 17 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15 1948, at 11A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 13 1948, to Feb. 15 1948, and that I last saw him alive on Feb. 15 1948.

Immediate cause of death Pulmonary tuberculosis — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary TB

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. R. Scarborough M. D.
Address Balto City Hosp. Date signed 2-16-48

G60245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

162 B

Registered No. G60245

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 21-1

(a) Baltimore City, Maryland

(b) Street address 27 N Carey St

(c) Hospital or institution: Good Samaritan Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 1003 BURGUNDY ST (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CATHERINE T CAWLEY

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM	WHITE	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV 31 - 1866

8. AGE: Years	Months	Days	If less than one day
81	2	16	hr. min.

9. Birthplace IRELAND (Town, county, and state)

10. Usual Occupation HOUSEWORK

11. Industry or business AT HOME

FATHER

12. Name PATRICK CAWLEY

13. Birthplace IRELAND

MOTHER

14. Maiden Name MARY GAFFNEY

15 Birthplace IRELAND

16 (a) Informant JOHN J COWLEY

(b) Address 1003 BURGUNDY ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-19-48 (month) (day) (year)

(c) Cemetery or crematory CATHEDRAL

Location OLD FREDERICK RD

18 (a) Funeral director Bernard E Hartle

(b) Address 121 E West St

19 (a) FEB 17 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 16 1948 at 1-P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 29th 1947, to Feb 16th 1948, and that I last saw her alive on Feb 16th 1948.

Immediate cause of death	Duration
Senile debility	
Due to Senile Changes	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify in part of place)

(e) Means of injury

23. Signature M.D.

Address 27 N Carey Date signed 2/16/48

VS 150

3246

X

G60246 E. 25th ST

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G60246 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 784 E - 28th st
(c) Hospital or institution: 94

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 784 E. 28th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louisa Willis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years	Months	Days	If less than one day
87			hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation
11. Industry or business Unemployed

FATHER
12. Name Curry Willis
13. Birthplace Va

MOTHER
14. Maiden Name not known
15. Birthplace "

16 (a) Informant Mattie Gaskins
(b) Address 784 E. 28th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 18th-48 (month) (day) (year)

(c) Cemetery or crematory
Location Carters Hill - Va.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bantley ave.

19 (a) FEB 17 1948 (Date rec'd by registrar) (b) Huntington West Virginia

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14th 1948, at 9.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9th 1948, to Feb 14/ 1948, and that I last saw h[illegible] alive on Feb 13/ 1948.

Immediate cause of death	Duration
Myocardial insufficiency	1 day
Due to	
Due to	
Other Conditions Arteriosclerosis ?	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address 401 E 25th St Date signed 2/16/48

G60247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 1a

G60247
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1178 N. Wolfe St
(c) Hospital or institution: 6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1178 N Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jos Dempsey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Married

6 (b) Name of husband or wife Mary Dempsey
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Terry N. C. (Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name Bill Dempsey
13. Birthplace Terry N. C.

MOTHER
14. Maiden Name Mary Carter
15. Birthplace Terry N. C.

16 (a) Informant Lee Dempsey
(b) Address 9 S. Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 18. 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Brooklyn Md

18 (a) Funeral director Chas. B. Wilson
(b) Address 1000 Brantly Ave

19 FEB 17 1948 (Date rec'd by local registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

6 10 P

20. DATE OF DEATH Feb 14 1948, at 6 19 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 10 1948 to 2 14 1948, and that I last saw h[illegible] alive on Jan. 14 1948.

Immediate cause of death	Duration
Bronchopneumonia	
Myocardial	
Due to Hypertension	
Negritic.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Trumbo M.D.
Address 1122 Lee Date signed 2/16/48

X

660248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 660248

660248

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 11 N. Monroe St.

(c) Hospital or institution: 20-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 11 N. Monroe St
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie K. Peahl

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife S. Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1871

8. AGE: Years	Months	Days	If less than one day
76	5	5	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edward Ackerman

13. Birthplace Germany

MOTHER 14. Maiden Name Mary Deer

15. Birthplace Md

16 (a) Informant S. Edward Peahl

(b) Address 715 Westminster Rd.

17 (a) Burial (b) Date thereof 2-18-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Catholic

Location Baltimore

18 (a) Funeral director George A. Farley

(b) Address Fulton and Fayette Sts.

19 (a) FEB 17 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/15 1948, at 6:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/30 1947 to 2/15 1948 and that I last saw h.e alive on 2/15 1948.

Immediate cause of death	Duration
Arteriosclerotic Cardio-Vascular Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Delmore Langlais M.D.

Address 40 N. Payson St. Date signed 2/17/48

VS 150

660249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registration No. 660249

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D. of A.
(b) Street address
(c) Hospital or institution: Provident Hospital 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1963 Perrish St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Elizabeth Cuff (Cuff)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife Willie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
71 70			hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Barney Johnson

13. Birthplace Md.

MOTHER 14. Maiden Name Rachel Wms.

15. Birthplace Md

16 (a) Informant Alberta Walker

(b) Address 1620 Presbury St

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 2/18/48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director Wm. H. Nelson

(b) Address 1303 Pennsylvania Ave

19 FEB 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/15 1948, at 1:45 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions Gangrene both legs

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ causes of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature C. P. Sabirski M.D. Medical Examiner.

Date signed 2/15/48

G60250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G60250 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1220 St James St
(c) Hospital or institution: 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1220 St James St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 15-1887

8. AGE: Years 60 | Months 5 | Days 1 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name C. Johnson
13. Birthplace Md

MOTHER 14. Maiden Name Susanna Watt
15. Birthplace Md

16 (a) Informant James Albert Johnson
(b) Address 1014 N Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 (month) 19 (day) 48 (year)

(c) Cemetery or crematory Mt Zion
Location Maryland Memorial Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E Preston St

19 FEB 12 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1948, at 8 30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 1948 to Feb 16 1948; and that I last saw him alive on Feb 15 1948.

Immediate cause of death	Duration
Pulmonary Embolism	
Due to Phlebitis	1 Month
Due to Diabetes Mellitus	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. K. Edmunds M. D.
Address 2222 N. Caroline St Date signed

X

G60251 B.A. Asst Room

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G60251

Med Ex Case

1. PLACE OF DEATH: Refused to Hosp.

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1714 E. Madison St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice Sharp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emanuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6 1879

8. AGE: Years 68 Months 7 Days 7 If less than one day hr. min.

9. Birthplace Alexandria Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Tom Allen

13. Birthplace Va

MOTHER

14. Maiden Name Mary ?

15. Birthplace Va.

16 (a) Informant JOHNS HOPKINS HOSPITAL

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 17 48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location A. A. County

18 (a) Funeral director Mrs Robt J Ellerth Dyk

(b) Address 1129 N. Caroline St.

19 (a) FEB 17 1948 (Date rec'd by Registrar) (b) Huntington Williams

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1948, at 11 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death Pericardial Tamponade with hemopericardium

Due to Dissecting Aneurysm of the aorta

Due to Syphilitic Aortitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Sherman Mellinkoff M. D.

Address Johns Hopkins Hosp. Date signed 2/14/48

for W. H. Kammer, by Howard D. Weidler, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C60252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. C60252

C60252

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1413 E. Eager St.

(c) Hospital or institution: 10-V

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1413 E. Eager St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Charles A Young

3 (b) If veteran, name war: World War # 1

3 (c) Social Security Account No. 216069385

4. Sex: M.

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8, 1894

8. AGE: Years 53 Months 4 Days 6 If less than one day hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Yellow Co.

FATHER 12. Name Dan Dodgers Young

13. Birthplace N. C.

MOTHER 14. Maiden Name Lula

15. Birthplace N. C.

16 (a) Informant Annie Young

(b) Address 1413 E. Eager St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 14, 1948 (month) (day) (year)

(c) Cemetery or crematory Bull. National Cem

Location

18 (a) Funeral director Mrs. Ott A. Elliott & Dyl.

(b) Address 1129 N. Caroline St.

FEB 17 1948 (Date received by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1948, at 1:08 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-3 1948 to 2-14 1948 and that I last saw him alive on 2-13 1948.

Immediate cause of death	Duration
Hypertensive cardio-vascular disease	unk.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Rayner Browne M. D.

Address 1500 E. Madison St Date signed 2-16

Rayner Browne

VS 150

660253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 660253

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 728 S. Ponca Street
(c) Hospital or institution: 26-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 728 S. Ponca Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Barbara Tucek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Karel Tucek
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1857

8. AGE: Years	Months	Days	If less than one day
90 91	6	-	hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Beran
13. Birthplace unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Emma Cogelia - daughter
(b) Address 728 S. Ponca Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/48 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 & 5 E. Madison Street

19 (a) FEB 17 1948 (Date rec'd by registrar) (b) Huntington for Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1948, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1947 to Feb 15 1948 and that I last saw h[illegible] alive on Feb 15 1948.

Immediate cause of death: Coronary Thrombosis — Duration 2/15/48

Due to Chr. Myocard. Ins — 1/1946

Due to Generalized Arterio Sclerosis — 1938

Other Conditions — (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Roemer, M.D.
Address 801 N. Calhoun St. Date signed 2/17/48

VS 150

660254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. 660254

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2707 Ashland Avenue
(c) Hospital or institution: 7-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2707 Ashland Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN FRANCIS BUCK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of [redacted] or wife Katherine (nee Langer)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1885

8. AGE: Years	Months	Days	If less than one day
62 63	11	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business Hubert Plumbing Co.

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Katherine Langer Buck
(b) Address 2707 Ashland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/48 (month) (day) (year)
(c) Cemetery or [redacted] Parkwood
Location Taylor Ave., Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-5 E. Madison Street

19 (a) FEB 17 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15, 1948, at 1 30 P. M.

21. I certify that death occurred on the date above stated that I attended deceased from Jan 1948 to Feb 15 1948.
and that I last saw h[illegible] alive on Feb 14 1948

	Duration
Immediate cause of death Pulmonary hemorrhage	days
Due to Malignancy	
Antecedent Causes Due to	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 200 [illegible] Date signed 2/16/48

VS 150

660255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660255

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3109 Beverly Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3109 Beverly Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Nicholas John Faulstich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of ~~husband~~ or wife Margaret (nee Dietrich)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 3, 1880

8. AGE: Years	Months	Days	If less than one day
67	6	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Nicholas Faulstich
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Schuhart
15. Birthplace Penna.

16 (a) Informant Mrs. Margaret Dietrich Faulstich
(b) Address 3109 Beverly Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/48 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Holy Redeemer
Location 4430 Belair Road, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-5 E. Madison Street

19 (a) FEB 17 1948 (Date rec'd by local registrar) (b) Waiting for Written Authority M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1948, at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to Feb 1948, and that I last saw him alive on Feb 13 1948

Immediate cause of death Uremia — Duration

Due to Chronic Generalized Arteriosclerosis and Hypertension

Due to

Other Conditions 2 Previous episodes of cerebral hemorrhage & recovery (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Brennan M. D.
Address 5217 Harford Road Date signed 2-16-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660256

660256 C 9766 106a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 12-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1904 Barclay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROBERT NELSON WAREHEIM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or Race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/21/47

8. AGE: Years	Months	Days	If less than one day
	2	17	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Harry
13. Birthplace Balto Md

MOTHER 14. Maiden Name Vivian
15. Birthplace Balto Md

16 (a) Informant Harry Warheim
(b) Address 1904 Barcley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-19-48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) FEB 17 1948 (Date rec'd by registrar) (b) Huntington Williams, Md Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17, 1948, at 6.55a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute tracheobronchitis.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 2-17-48

X

G60257
AB–15962

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G60257

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 4-1
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 72yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 730 East Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Morgan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15–1859

8. AGE: Years	Months	Days	If less than one day
88	[illegible]	[illegible]	hr. min.

9. Birthplace N.Y. (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Edward Morgan
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Klein
15. Birthplace Wales

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/48 (month) (day) (year)
(c) Cemetery or crematory Forest Lawn Cemetery
Location Berman Mill Road

18 (a) Funeral director J. J. Faber Sons
(b) Address 1818 Light St.

19 (a) FEB 17 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION PM

20. DATE OF DEATH Feb. 6– 1948, at 12.30M

21. I certify that death occurred on the date above stated; that I attended deceased from 6–26– 1935 to 2–6– 1948, and that I last saw him alive on 2–6– 1948.

Immediate cause of death Cardiac failure — Duration
Due to Arteriosclerotic Heart Disease
Due to
Other Conditions Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. T. Bamford M. D.
Address Balt. City Hosp. Date signed 2-14-48

660258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. 660258

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3501 White Chapel Rd
(c) Hospital or institution: — 15-11
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3501 White Chapel Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sigmund Samuel Kohn.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower.

6 (b) Name of husband or wife Berta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6 1869

8. AGE: Years	Months	Days	If less than one day
78	3	9	hr. min.

9. Birthplace Vienna Austria (Town, county, and state)
10. Usual Occupation Wine Steward.
11. Industry or business —

FATHER
12. Name Leopold
13. Birthplace Vienna Austria

MOTHER
14. Maiden Name Lanette Steiner
15. Birthplace Vienna Austria

16 (a) Informant Daughter Jean Epstein
(b) Address 3501 White Chapel Rd

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/18/48 (month) (day) (year)
(c) Cemetery or crematory Roosevelt
Location Philadelphia, Pa.

18 (a) Funeral director Harris Sonnheim & Son
(b) Address 1902 Eutaw Place

19 FEB 17 1948 (Date rec'd by Registrar) (b) Funeral for Williamsburg, Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15 1948, at 11.20 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1943 to Feb. 15 1948, and that I last saw him alive on Feb. 15 1948.

	Duration
Immediate cause of death: Coronary Thrombosis	Sudden
Due to: Arteriosclerotic Cardiovascular Renal Disease	?
Due to:	
Other Conditions: Carcinoma of Bladder	4 yr.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph J. Blum M. D.
Address 106 E. Preston St. Date signed 2/16/48

VS 150

660259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

660259 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9da
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Temple Gardens, Apts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Mrs. Joseph Levie (Julia)
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: Mr. Joseph Levie
6 (c) If give, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 26, 1877
8. AGE: Years 71 | Months 0 | Days 22 | If less than one day hr. — min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Nathan Hass
13. Birthplace Germany

MOTHER
14. Maiden Name Molly Lowenstein
15. Birthplace Germany

16 (a) Informant Mrs. Sidney B. Kohn
(b) Address Temple Gardens Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/48 (month) (day) (year)
(c) Cemetery Bonaventure Location Bonaventure, Md.

18 (a) Funeral director Harris Sonnenstrahl Son
(b) Address 1902 Eutaw Place

19 (a) Filed 2-19-1948 (b) Registrar Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17 1948 at 8:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 8 1948 to Feb 17 1948 and that I last saw h[illegible] alive on Feb 17 1948.

Immediate cause of death: Myocardial insufficiency — Duration: 3 days
Due to: Coronary occlusion
Due to: Coronary artery disease of sclerotic nature
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mortimer Lee Hillman M. D.
Address Union Memorial Hosp. Date signed 2-19-48

VS 150

660260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 660260

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1024 Booths St.
(c) Hospital or institution: 18-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1024 Booth St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alverta Calhoun. (250)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Widow

6 (b) Name of husband or wife Edward Calhoun
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 4, 1877

8. AGE: Years	Months	Days	If less than one day
70	6	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Blanche Bailey
(b) Address 933 W. Fayette St.

17 (a) Burial (b) Date thereof Feb. 17 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (a) FEB 17 1948 (b) Washington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 1948, at 2:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1947 to Feb 17 1948
and that I last saw h[illegible] alive on Feb 13 1948

Immediate cause of death
Due to Cerebral hemorrhage
Due to Hemiplegia

Duration 10 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Boose M. D.
Address 1 W Saratoga St Date signed 2/17/48

VS 150

660261 C 15157 161c

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660261

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Bon Secours Hosp.
(a) Baltimore City, Maryland
(b) Street address Fayette & Payson Sts.
(c) Hospital or institution: 18-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4115 GROVELAND AVE.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME TIMOTHY EDGAR HENRY III.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 02 1947

8. AGE: Years	Months	Days	If less than one day
0	2	24	hr. min.

9. Birthplace BALTIMORE
(Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER
12. Name TIMOTHY E. HENRY II
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name WANDA D. SCHAFFER
15. Birthplace CARROLL CO., MD.

16 (a) Informant MRS. TIMOTHY E. HENRY
(b) Address 4115 GROVELAND AVE

17 (a) BURIAL (b) Date thereof 2/18/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory KRIDERS CEM.
Location CARROLL CO. MD.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address BALTIMORE, MD.

19 (a) FEB 17 1948 (b) Huntington Nelligan M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1948 at 10:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24 1948 to Feb 16 1948 and that I last saw him alive on Feb 16 1948

Immediate cause of death	Duration
Respiratory failure	
Due to Cor. Pulmonale Hypertonia	
Due to Secondary to transfusion	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William R. Lamar M. D.
Address Bon Secours Hosp. Date signed 2-16-48

VS 250

660262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

660262 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 15-9

(a) Baltimore City, Maryland

(b) Street address 2117 DENISON ST.

(c) Hospital or institution: CRAWFORD NURSING HOME

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in Baltimore (yrs., mos., or days) 60YRS

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County —

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 3803 CLIFTON AVE (If rural give location)

(e) Citizen of foreign country? — (Yes or No) If yes, name country —

3 (a) FULL NAME GEORGE U. MEYERS

3 (b) If veteran, name war: NONE

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	WIDOWED

6 (b) Name of husband or wife: DORA

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): NOV. 27, 1867

8. AGE: Years	Months	Days	If less than one day
80	2	19	..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation: RETIRED - BUTTER & EGGS

11. Industry or business: SELF.

FATHER 12. Name: HAMPSTEAD GEO. MYERS

FATHER 13. Birthplace —

MOTHER 14. Maiden Name: MARY MYERS

MOTHER 15. Birthplace: MANCHESTER, MD.

16 (a) Informant: MR. PAUL E. MYERS

(b) Address: 3803 CLIFTON AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/19/48 (month) (day) (year)

(c) Cemetery or crematory: BLACK OAK CEM. Location: BUTLER, MD

18 (a) Funeral director: WM. J. TICKNER & SONS

(b) Address: BALTIMORE, MD.

19 (a) FEB 17 1948 (Date received by registrar) (b) Huntington for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/16/48, 19..., at 1.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from OCT. 14 1947 to 2/16/48 19..., and that I last saw him alive on 2/16/48 19...

Immediate cause of death: Myocarditis — Duration: 4 MO

Due to: —

Due to: Advanced Arteriosclerosis

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy: —

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —

(e) Means of injury —

23. Signature: Charles L. Huntington M. D.

Address 2220 Harrison Blvd. Date signed 2/17/48

VS 150

G50263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50263

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 W. ROGERS AVE
(c) Hospital or institution: METHODIST HOME FOR THE AGED
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 YRS.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 W. ROGERS AVE
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH A. WARE

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: WIDOWED
6 (b) Name of husband or wife: JAMES E. WARE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): APR. 10, 1862

8. AGE: Years 85 | Months 10 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace: BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation: NONE

11. Industry or business

FATHER
12. Name: GEORGE PEDDICORD
13. Birthplace: BALTO, MD.

MOTHER
14. Maiden Name: SARAH STEELE
15. Birthplace: BALTO, MD.

16 (a) Informant: MRS. MAMIE B. FISHER
(b) Address: 211 W. ROGERS AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/20/48 (month) (day) (year)
(c) Cemetery or crematory: LORRAINE
Location: BALTO CO. MD.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: BALTO, MD.

19 (a) FEB 17 1948 (Date rec'd by registrar) (b) Huntington Wi... Louisville, Ky.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/17/48 19..., 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1948 to Feb 16 1948.
and that I last saw h... alive on Feb 16 1948.

	Duration
Immediate cause of death: Myocardial Insufficiency	5 days
Due to: Arterio Sclerosis	20 yrs
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Arthur J Davies M. D.
Address 800 W 32nd St Date signed 2-17-48

X

C60264

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 147c

Registered No. C60264

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: 13-7
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Oakland St
(c) Hospital or institution: Nat Baltimore Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3754 Hickory Avenue (If rural give location)
(e) Citizen of foreign country? Not (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Kates

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mabel F. Kates
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22-1882

8. AGE: Years	Months	Days	If less than one day: hr.	min.
65	8	23		

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Policeman
11. Industry or business

FATHER
12. Name George Kates
13. Birthplace New Jersey

MOTHER
14. Maiden Name Mary Livingston
15. Birthplace Ireland

16 (a) Informant Mrs. Mabel F. Kates
(b) Address 3754 Hickory Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 19-1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) FEB 17 1948 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1948, at 9:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1948, to Feb 15 1948, and that I last saw him alive on Feb 15 1948.

Immediate cause of death	Duration
Cerebrovascular accident	
Due to Generalized arterio-sclerosis	
Due to	
Other Conditions Bronchogenic carcinoma (Include pregnancy within 3 months of death)	

Date of operation Feb 14, 1948
Major findings of operation: Bronchogenic Carcinoma, Rt.
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G. Robert Hardy M.D.
Address Nat Bal Gen'l Hosp Date signed 2/15/48

VS 150

X

660265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √180

660265 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 8-7
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1747 E Oliver Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BRYANT SANFORD TRAIL

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 25, 1947

8. AGE: Years 6 | Months 7 | Days 21 | If less than one day hr. min.

9. Birthplace BALTIMORE, MD (Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER 12. Name J. Kenneth E. Trail
13. Birthplace BALTIMORE, MD

MOTHER 14. Maiden Name [redacted] MARY SANFORD
15. Birthplace BALTIMORE MD

16 (a) Informant MRS. MARY TRAIL
(b) Address 1747 E. OLIVER ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/ /48 (month) (day) (year)
(c) Cemetery or crematory ST. MARY'S HANDEL
Location BALTIMORE, MD

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 PARK HEIGHTS AVE

19 (a) FEB 17 1948 (Month, day, and year) (b) Huntington Williamsport, Md.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-16 1948, at 8 30 A M

21. I certify that I took charge of the remains described above, held an Inspection and Inq Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Suffocation from inhalation of smoke.
Extensive burns

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-16-48 at approx 8 A M
(b) Where did injury occur? 1747 E. Oliver St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Conflagration (or fire)

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 2/16/48

G60266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G60266

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. 6-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 E Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Delfina Fernandez. Dolfina Fernandez

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: F. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jose

6 (c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): March 4 1895

8. AGE: Years: 52 | Months: 11 | Days: 11 | If less than one day: hr. min.

9. Birthplace: Spain (Town, county, and state)

10. Usual Occupation:

11. Industry or business: At Home

FATHER 12. Name: Jose Rodriguez

13. Birthplace: Spain

MOTHER 14. Maiden Name: Maria Vasquez

15. Birthplace: Spain

16 (a) Informant: Jose Fernandez

(b) Address: 1707 E. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 19 48 (month) (day) (year)

(c) Cemetery or crematory: Holy Redeemer

Location: 4300 Belair Rd

18 (a) Funeral director: Dippel Bros

(b) Address: 1800 E Lombard St

19 Date received by Registrar: FEB 17 1948 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 Feb 1948, at 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9 Feb 1948 to 15 Feb 1948, and that I last saw her alive on 15 Feb 1948

Immediate cause of death: Cardiorespiratory arrest — Duration:

Due to: Hypertension arteriosclerotic cardiovascular disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Bernard S Cohen M. D.

Address: Sinai Hosp., Balto Md Date signed: 15 Feb 48

X

660267

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. 660267

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5805 Halwyn Avenue
(c) Hospital or institution: 27-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5805 Halwyn Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John W.Williams

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 213-10-5340

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary E.Terry
6 (c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Jan.27th.,1898

8. AGE: Years: 50 | Months: 0 | Days: 20 | If less than one day: ######## min.

9. Birthplace: Baltimore,Md. (Town, county, and state)

10. Usual Occupation: Supt.of Production

11. Industry or business: Buck Glass Co.

FATHER
12. Name: Francis H.Williams
13. Birthplace: Canada

MOTHER
14. Maiden Name: Mary E.Ward
15. Birthplace: Baltimore,Md.

16 (a) Informant: Mary E.Williams -- Wife
(b) Address: 5805 Halwyn Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/48. (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Edmondson Ave.Balto.Md.

18 (a) Funeral director: George J.Ruth,Inc.
(b) Address: 1735 Harford Avenue

19 (a) FEB 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb.16 1948, at 2 9. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 1948 to 2/16 1948
and that I last saw h[illegible] alive on 2/15 1948.

Immediate cause of death: Acute cardiac failure due to coronary occlusion -- anterior. — Duration: 13 min.
Due to: coronary disease with infarction
Due to:
Other Conditions: none
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Harry Leapley
Address: 226 Hendee St. Date signed: 2/16/48

V S 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

650268

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

650268
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 26-12
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John BAKER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 63 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School FEB 6 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 17 1948 (Date rec'd by registrar) (b) J. J. Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21, 1948, at 5:45 a M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Myocardial degeneration.
Acute pulmonary edema.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 1/22/48

660269

48-11551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. 660269

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 17-1 DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 922 Argyle Avenue
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME BABY JACKSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/25/48

8. AGE: Years	Months	Days	If less than one day
		1	.....hr. .....min.

9. Birthplace.....
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name.....
13. Birthplace.....

MOTHER
14. Maiden Name.....
15. Birthplace.....

16 (a) Informant.....
(b) Address.....

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location University Medical School FEB 6 1948

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 (a) FEB 17 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 1948, at 11:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Dilatation of heart.

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur in home, on farm, industrial place, in public place? ..... While at work?.....
(d) Means of injury.....

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 1-26-48

660270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

104a

Registered No. 660270

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 2100 Highland Point Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME DONALD DREES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/1[illegible]

8. AGE: Years	Months	Days	If less than one day
	1		hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School FEB 6 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 17 1948 (Date rec'd by registrar) (b) [signature] Registrar

VS. 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31, 1948, at 10.25 a

21. I certify that I took charge of the remains described above, held an autopsy, thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Upper Respiratory Infection
Influenza

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner

Date signed 2-3-48

60271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164 B

660271 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 7-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Joseph Ballman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
50?			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School FEB 6 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7, 1948, at 7.45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH (a) Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-7-48 at 7 P. M. 3/2
(b) Where did injury occur? Harbor- Caroline St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found drowned.

23. Signature Earl L. Page M.D. Medical Examiner.
Date signed 1-8-48

660272 SC-48-02786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. 660272

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted]
(c) Hospital or institution: University Hosp 16-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 N. Monroe
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country No

3 (a) FULL NAME Constance Ferguson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-2-48.

8. AGE: Years [redacted] Months 8 Days If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name James
13. Birthplace S. C.

MOTHER
14. Maiden Name Doris Richardson
15. Birthplace Md.

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location City Hospital

18 (a) Funeral director

(b) Address

19 (a) FEB 17 1948 (Date rec'd by registrar) (b) [illegible]

University Medical School FEB 16 1948
Commissioner of Health

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1948, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-9 1948, to 2-10 1948, and that I last saw h er alive on 2-10 1948.

Immediate cause of death Respiratory failure

Due to Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Subarachnoid hemorrhage

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Robert C. Hunter M.D.
M. D.

Address University Hosp. Date signed 2-10-48

VS 150

660273

City Disposal

BC-48-03223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167c

Registered No. 660273

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1422 Prestman
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1422 Prestman St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Phyllis Craig

3 (b) If veteran, name war no

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 - 12 - 48

8. AGE: Years 0 | Months 0 | Days → | If less than one day 14 hr. 45 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Charles Craig
13. Birthplace Charleston N.C.

MOTHER
14. Maiden Name Gertrude Crawley
15. Birthplace Baltimore Md

16 (a) Informant Mother: Gertrude Craig
(b) Address 1422 Prestman

17 (a) (Burial, cremation, or removal) **(b) Date thereof** (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School FEB 16 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 17 1948 (Date received by Registrar) **(b)** Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Friday 2/13 1948, at 9:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-12 1948, to 2-13 1948, and that I last saw her alive on 2-12 1948.

Immediate cause of death	Duration
shock, hemorrhage	
Due to hemorrhage from umbilical cord	
Due to	
Other Conditions probable bleeding diathesis (Include pregnancy within 3 months of death)	
Date of operation no	
Major findings of operation: no	
of autopsy: —	

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Lantz M.D.
Address Univ. Hosp. Date signed 2/13/48

X

G0274

BC-48-02320

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1579

Registered No. G0274

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 14 1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 204 Laurens St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Chatman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/3/48

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Sam Chatman
13. Birthplace Va

MOTHER
14. Maiden Name Eloise Chatmans
15. Birthplace Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 10 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) (Date received by Registrar) (b) Baltimore, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 1948, at 2:17 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1948 to Feb 6 1948 and that I last saw him alive on Feb 6 1948.

Immediate cause of death	Duration
Resp. failure	
Due to Intestinal Obstruction	
Due to Imperforate Anus	3 Days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2-5-48

Major findings of operation: Intestinal Obstruction

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F. Engle, Jr. M. D.
Address The Johns Hopkins Hosp. Date signed 2-16-48

VS 150

660275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 660275

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1712 N. Calhoun St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1712 N. Calhoun St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Julia M. Reems

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Augustus

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 6, 1885

8. AGE: Years: 62 | Months: 7 | Days: 6 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER — 12. Name: Unknown

13. Birthplace

MOTHER — 14. Maiden Name: Unknown

15. Birthplace

16 (a) Informant: Mrs. Celia Stims

(b) Address 1712 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/48 (month) (day) (year)

(c) Cemetery or crematory Rockville, Md

Location Rocky Hill

18 (a) Funeral director Mrs. Chas. H. Holland

(b) Address 1631 Druid Hill Ave

19 (c) FEB 17 1948 (Date received by local registrar) (b) Thomas for Williams M.W. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1948, at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1948 to Feb 14 1948, and that I last saw her alive on Feb 14 1948.

Immediate cause of death	Duration
Coronary thrombosis	Month
Due to Arter-sclerosis	—
Due to Hypertension	—
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Fred K. Patterson M. D.

Address (72) Druid Hill Ave Date signed

VS 199

X 2-16-48

0276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

Registered No. 0276

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 118 N. Exeter St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IRA JONES

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	S,

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace Georgia
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace "

MOTHER 14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant J. Jones
(b) Address 118 N. Exeter St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/48 (month) (day) (year)
(c) Cemetery or crematory
Location Spartanburg, South Carolina

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Brantly Ave

19 (a) FEB 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14, 1948, at 4.55PM

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wounds of chest -

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-14-48 at 4 p. M.
(b) Where did injury occur? Green Front Tavern- Exeter & Lexington Sts. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Outside tavern Firearms

23. Signature [signature] M.D.
Medical Examiner
Date signed 2-16-48

(50277) 1948 Dec

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1.13B

Registered No. (50277)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4007 Orchard Ave Balto 25 Md
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) ~~State~~ Md (b) County
(c) City or town Balto - Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4007 Orchard Ave
(If rural give location)
(e) Citizen of foreign country? No - (Yes or No)
If yes, name country

3 (a) FULL NAME William G. FERRICK

3 (b) If veteran, name war

3 (c) Social Security Account No. 178-05-0563

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~: Bertha Ferrick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2-1894

8. AGE: Years 53 | Months 10 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace Penn
(Town, county, and state)

10. Usual Occupation Silver smith

11. Industry or business Kirks Silversmith

FATHER
12. Name Joseph Ferrick
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Botir
15. Birthplace Poland

16 (a) Informant Mrs Bertha Ferrick
(b) Address 4007 Orchard Ave

17 (a) Burial (b) Date thereof Feb 21-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St Stanislaus
Location Shamokin Penn

18 (a) Funeral director Milton Schilling
(b) Address 3914 Hanover St

19 (FEB 17 1948) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17th 1948, at 9.30 A-M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Anthraco-silico-tuberculosis, of lungs
Hypertrophy and dilatation of
~~Due to~~ right ventricle of heart.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 2/17/48

VS 151

660278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83 B

Registered No. 660278

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St. 9-9

(c) Hospital or institution: St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1319 Greenmount Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Pasek

3 (b) If veteran, name war W

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
71 70			hr. min.

9. Birthplace Hungary (Town, county, and state)

10. Usual Occupation Orderly

11. Industry or business St. Jos. Hosp.

FATHER 12. Name Unknown

13. Birthplace ?

MOTHER 14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Margaret Bond

(b) Address 6417 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md.

18 (a) Funeral director Wilson Godfrey

(b) Address 1214 N. Paca St.

FEB 18 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/16 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/9 1948, to 2/16 1948. and that I last saw h/M alive on 2/16 1948

Immediate cause of death Cerebral Thrombosis — Duration

Due to Hypertension, Essential

Due to

Other Conditions Generalized Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Henry J. Sonneborn M.D.

Address St. Jos. Hosp. Date signed 2/16/48

V S 150

660279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 16

Registered No. 660279

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St.
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30
(e) Length of stay in Baltimore (yrs., mos., days) 42

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 30
(If outside city or town limits, write RURAL and give town)
(d) Street No. 627 Wyeth St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Mathias

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-1455

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed or divorced married

6 (b) Name of husband or wife Lillian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/22/04

8. AGE: Years 43 42 | Months 2 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Operater

11. Industry or business Balto. Transit Co.

FATHER
12. Name William Mathias
13. Birthplace Maryland

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Lillian Mathias
(b) Address 627 Wyeth Street

17 (a) 2/21/48 (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore, Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul Street

19 FEB 1 0 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/17/48 19... at 9¼ M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/16/ 1948 to 2/17/ 1948 and that I last saw h.. alive on 2/17/48

Immediate cause of death	Duration
Cardio Respiratory Failure	
Due to Generalized toxemia and sepsis.	
Due to Psoas abscess Gangrenous abscesses of pelvic & Thigh muscles & Sub Q tissue	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Psoas abscess.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Clotilda Barley
Address St Joseph's Hosp Date signed 2/17/48

460280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

Registered No. 460280

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 32nd + Calvert Sts
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto. Co.
(c) City or town Ruxton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Doris Ray

3 (b) If veteran, name war	3 (c) Social Security Account No.
	—

4. Sex	5. Color or race	6 (a) Single, (married) widowed, or divorced.
F	W	

6 (b) Name of husband or wife Edward Ray
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Nov 8, 1895

8. AGE: Years	Months	Days	If less than one day
52	3	9	hr. min.

9. Birthplace Baltimore, Md
(Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Fallon
13. Birthplace England

MOTHER
14. Maiden Name —
15. Birthplace England

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/48 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Monrovia Md

18 (a) Funeral director Wilhorn Cook Jones
(b) Address 1217 St Paul St

19 (a) FEB 18 1948 (Date rec'd by registrar) (b) Registrar's signature Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-17 1948 at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16 1948 to 2-17 1948 and that I last saw h[illegible] alive on 2-17 1948

Immediate cause of death Cerebral vascular accident — Duration 5 days

Due to Rheumatic heart disease — 40 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George O. Kamm M. D.
Address 33rd & Calvert Sts Date signed 2-17-48

VS 150

G50281 GM.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G50281

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Months
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3135 McElderry ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ernest Sollers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Bertha
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28 -1877

8. AGE: Years	Months	Days	If less than one day
70	3	19	hr. min.

9. Birthplace MD. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Andrew Jackson Sollers
13. Birthplace MD.

MOTHER
14. Maiden Name Francis Frazier
15. Birthplace N.Y.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore MD

18 (a) Funeral director Wilhelm & Hafer
(b) Address 1214 E. Fayette St

FEB 18 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2- 16- 1948, at 10:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11- 9 -1947, to 2 - 16 - 1948, and that I last saw h im alive on 2 - 16 - 1948.

Immediate cause of death	Duration
Congestive Failure	
Due to Coronary Hypertrophy & dilatation. A.S.H.D.	
Due to	
Other Conditions Alcoholism	
Operations, Appendectomy, Hemorrhoids (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Absence

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice M. Lacy, M.D. M. D.
Address Balt. City Hosp. Date signed 2-17-48

VS 150

93D

660282

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131 B

Registered No. 660282

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 448 W. Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SALLIE CUNNINGHAM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jun. 1907

8. AGE: Years	Months	Days	If less than one day
40	8		hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Pink Greer
13. Birthplace N.C.

MOTHER
14. Maiden Name Alice Hinton
15. Birthplace N. C.

16 (a) Informant Mr. John Cunningham
(b) Address 448 W. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-19-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location A. A. Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) FEB 18 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16, 1948, at 10.20 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic glomerular nephritis
Arteriosclerotic cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emily V. Kenyon M.D.
Medical Examiner.
Date signed 2-17-48

VS 151

G60283

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 123

Registered No. G60283

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Broadway
(c) Hospital or institution: Church Home & Hospital 26-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 251
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 719 Dean St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Sengfelder
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife George Sengfelder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 9, 1875

8. AGE: Years 72 | Months 10 | Days 8 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Weiss, John
13. Birthplace Germany

MOTHER
14. Maiden Name Miss K. Haffner
15. Birthplace Germany

16 (a) Informant Minnie Sengfelder
(b) Address 719 Dean St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 20th (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Catty

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St

19 FEB 18 1948 (Date rec'd by Registrar) (b) Huntington Ave

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17, 1948 at 9:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-16-47 19.. to 2-17 1948, and that I last saw her alive on 2-17- 1948.

Immediate cause of death Terminal Cardiac failure — Duration 4 hrs

Due to Intra peritoneal opening of Cecostomy — Duration

Due to Diverticulosis & Intestinal Obstruction — Duration 7 days

Other Conditions Retroperitoneal + lumbar abcess — Duration 15 years ? ~~5 hrs~~?
(Includes pregnancy within 3 months of death)

Date of operation 6/21/47; 10/2/47; 2/9/48

Major findings of operation: Diverticulosis + extra peritoneal abcess

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lee Howard, M.D.
M. D.
Address Church Home + Hosp Date signed 2/17/48

VS 150

X

C60284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C60284
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2815 Erdman Ave
(c) Hospital or institution: 8-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2815 Erdman Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Loesch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Loesch
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Jan 26 1889

8. AGE: Years 59 | Months - | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Upholsterer

11. Industry or business

FATHER
12. Name Henry F. Loesch
13. Birthplace Balto

MOTHER
14. Maiden Name Elizabeth Miller
15. Birthplace Balto

16 (a) Informant Mrs Hetta Loesch
(b) Address 2815 Erdman ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 19th (month) (day) (year)
(c) Cemetery or crematory Lot H Ea Cem City
Location

18 (a) Funeral director Leberth Funeral Home
(b) Address 2008 Aliceanna St

19 (a) FEB 18 1948 (Date rec'd by reg'r) (b) Number Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 16th 1948, at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940 to Feb 16 1948, and that I last saw h[illegible] alive on Feb 15 1948.

Immediate cause of death: Coronary Occlusion — Duration 5 mos.
Due to: Chronic Myocarditis — 1 year
Due to: arteriosclerosis — 1 year
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Egbert L. Mortimer Jr M.D.
Address 2708 St Paul St Date signed 2/16/48

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50285 EL. 117156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30 D

Registered 50285

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospital 16-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 820 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. Willis Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	Married

6 (b) Name of husband or wife Mary Virginia Stewart
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-21-83

8. AGE: Years	Months	Days	If less than one day
65 ?	3	26	hr. min.

9. Birthplace Federalsburg Md.
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Alexandra Stewart
13. Birthplace Md. ?

MOTHER
14. Maiden Name Josephine Holliday
15. Birthplace Md

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 2-19-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.

19 (a) FEB 18 1948 (b) Huntington Williams Mortuary
(Date rec'd by Reg. Dist.) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1948, at 7-08 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 3 1948, to Feb. 16 1948, and that I last saw him alive on Feb. 16 1948.

Immediate cause of death	Duration
Cardiac failure.	
Due to Syphilitic & Arterio-sclerotic Heart Disease	
Due to	
Other Conditions Arterio-sclerotic nephrosclerosis.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy Syphilitic aortitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. T. Binford M. D.
Address Balt. City Hosp. Date signed 2-17-48

VS 150

660286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. 660286

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 536 N. Castle St.
(c) Hospital or institution: 7-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 536 N. Castle St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas R. Stavely

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Maud T. Stavely

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29-1881

8. AGE: Years 66 | Months 4 | Days 17 | If less than one day hr. min.

9. Birthplace Kent Co. Md. (Town, county, and state)

10. Usual Occupation Baker retired

11. Industry or business

FATHER 12. Name Thomas H. Stavely

13. Birthplace Md.

MOTHER 14. Maiden Name Mary J. Hodges

15. Birthplace Md.

16 (a) Informant Mrs. Maud T. Stavely

(b) Address 536 N. Castle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/48 (month) (day) (year)

(c) Cemetery or crematory Western

Location Baltimore

18 (a) Funeral director Philip Herwig Sons

(b) Address 2024 Orleans St.

19 (a) FEB 18 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1948, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1948 to Feb 16 1948 and that I last saw h alive on Feb. 19 1948

Immediate cause of death: Myocardial failure — Duration: 3 days

Due to: Uremia — Duration: 1 week

Due to: Arteriosclerosis, Senility, Hemiplegia — Duration: 5 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clarence W. LeGoux M.D.

Address 601 Ellwood Ave. Date signed 2/17/48

V S 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

60287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 60287

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1521 CLIFTON AVE.
(c) Hospital or institution: 13-3
(d) Length of stay in ~~hospital or inst.~~ (yrs., mos., or days) 13 YRS. (ABOVE ADDRESS)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE, MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1521 CLIFTON AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LENA C. ALLENDER

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: WM. J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 21, 1879

8. AGE: Years 68 | Months 10 | Days 23 24 | If less than one day: hr. min.

9. Birthplace BALTO. CO. MD.
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business —

FATHER
12. Name GEORGE FRAGER
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARY MINCHEY
15 Birthplace CARROLL CO. MD.

16 (a) Informant MR. WM. J. ALLENDER
(b) Address 1521 CLIFTON AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/18/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ DRUID RIDGE
Location PIKESVILLE, MD.

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address 1 BALTIMORE, MD.

19 (a) FEB 18 1948 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/14/48 19 10-45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 19 48 to Feb 14 19 48, and that I last saw h[illegible] alive on Feb 14 19 48.

Immediate cause of death: Carcinoma Pancreas — Duration 4 mos.
Due to: Arterio-Sclerosis
Due to:
Other Conditions: Senile Dementia — 1 yr.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry C. Houck M. D.
Address 1929 W. North Ave. Date signed 2/16/48

Henry C. Houck

G60288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G60288 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens Ave.
(c) Hospital or institution: St. Agnes 20-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County [illegible]
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2312 Frederick Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country —

3 (a) FULL NAME Caroline F. Walters

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife ROBERT F. (deceased)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 11, 1870

8. AGE: Years 77 | Months 1 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name John H. Landwehr
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Fauth
15. Birthplace Md.

16 (a) Informant Miss Elizabeth Landwehr
(b) Address 2315 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/48 (month) (day) (year)
(c) Cemetery or crematory London P.K.
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Roach & Pd. Aves. Balto. Md.

19 FEB 18 1948 (Date rec'd by registrar) (b) Registrar [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/17 1948, at 1100 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/17 1948 to 2/17 1948 and that I last saw h.c.r. alive on 2/17 1948.

Immediate cause of death Arteriosclerotic hypertensive cardiovascular disease with

Due to fibrillation + multiple emboli

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: —

of autopsy: none performed

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —— at —— M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Herbert J. Lerches, M.D.
Address St Agnes Hosp. Date signed 2/17/48

VS 150

160289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

Registered No. 160289

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd.
(c) Hospital or institution: Union Memorial Hosp 27-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 da
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5210 St Albans Way
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** PHILIP WILLIAMS CHASE

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife DOROTHY B. CHASE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT 13, 1883

8. AGE: Years	Months	Days	If less than one day
64	5	4	hr. min.

9. Birthplace BALTIMORE, MD
(Town, county, and state)
10. Usual Occupation Executive
11. Industry or business J. S. JOHNSON Co.

FATHER
12. Name John H. Chase.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Hannah H Clenborough
15. Birthplace Conn.

16 (a) Informant Wife
(b) Address 5210 ST ALBANS WAY

17 (a) BURIAL (b) Date thereof 2/20/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory DRUID RIDGE
Location PIKESVILLE, MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTO. MD.

19 (a) FEB 18 1948 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 1948 at 11:43 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 31 1948 to Feb 17 1948 and that I last saw HIM alive on Feb 17 1948.

Immediate cause of death	Duration
Hepatic insufficiency	3 wk
Due to Metastases from & generalized	5 mo.
Due to Carcinoma of bladder	9 mo
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman Jr. M.D.
Address Union Memorial Hosp. Date signed Feb 17/48

VS 150

X

660290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 660290

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3501 DOLFIELD AVE

(c) Hospital or institution: 15-11

(d) Length of stay in ~~hospital or inst.~~ (yrs., mos., or days) ABOVE ADDRESS 4 YR.

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 3501 DOLFIELD AVE (If rural give location)

(e) Citizen of foreign country? — (Yes or No) If yes, name country

3 (a) FULL NAME LAURA M. BRANNAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-03-6387

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife JOHN J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR. 10, 1877

8. AGE: Years	Months	Days	If less than one day
70	10	7	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation FUR FINISHER

11. Industry or business BOUVIT LENNON

FATHER 12. Name JOHN W. CANAPP.

13. Birthplace BALTIMORE, MD.

MOTHER 14. Maiden Name SARAH V. BASEMAN

15. Birthplace BALTIMORE, MD.

16 (a) Informant MRS. THELMA LINTON

(b) Address 3501 DOLFIELD AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/20/48 (month) (day) (year)

(c) Cemetery or crematory ST. MARY'S (HAMPDEN)

Location BALTIMORE, MD.

18 (a) Funeral director WM. J. TICKNER & SONS INC

(b) Address NORTH & FA. AVES., BALTO., MD.

19 FEB 18 1948 (Date received by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/17/48, at 9:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 11 1948 to Feb 17 1948, and that I last saw HER alive on Feb 15 1948.

Immediate cause of death	Duration
Acute cardiac Dilatation + Pulmonary Edema	9 hours
Due to Hypertensive cardio vascular disease	years?
Due to arteriosclerosis	
Other Conditions Left lobar pneumonia 7 days	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature William J. Ludiwan M. D.

Address 2911 Garrison Blvd Date signed 2-18-48

VS 180

937

C60291 HL. 117403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. C60291

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospital 21-T
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 42 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 901 S. Paca St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Edgar Broach

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Widowed

6 (b) Name of husband or wife Betty Broach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25 1860

8. AGE: Years	Months	Days	If less than one day
87 Years	4	21	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name George Broach
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Ellen Brimm
15. Birthplace Va.

16 (a) Informant Baltimore City Hospital Record
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2 19 48 (month) (day) (year)
(c) Cemetery or crematory MOUNT OLIVET
Location FREDERICK RD.

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST -30

19 FEB 18 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1948, at 10-A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1948 to Feb. 16 1948, and that I last saw him alive on Feb. 16 1948

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	8 yr
Due to	
Due to	
Other Conditions Terminal Pneumonia (Include pregnancy within 3 months of death)	1 wk
Date of operation	
Major findings of operation:	
of autopsy: an alcove	

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. C. Peshenian Jr.
Address Balt. City Hosp. Date signed 2/16/48 M.D.

G60292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G60292

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison Street
(c) Hospital or institution: Home 15-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2117 Dennison Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia G. Feddeman

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Samuel E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1876

8. AGE: Years	Months	Days	If less than one day
71	11	21	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation -
11. Industry or business -

FATHER
12. Name S. Rawlings Goodwin
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Ja Hopkins
15. Birthplace Md.

16 (a) Informant Mrs. J.F. Moses
(b) Address 704 Gladstone Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb.19-48 (month) (day) (year)
(c) Cemetery or crematory Chesterfield Cemetery
Location Centerville, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

FEB 18 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1948, at 8:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1947 to Feb 1948 and that I last saw h-r alive on Feb 16 1948.

Immediate cause of death Carcinoma of Uterus — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J Kelbick M. D.
Address 2/18/48 Date signed 2/18/48
5006 Roland Ave

660293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 660293

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1916 Breitwert Avenue
(c) Hospital or institution: home 25-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1916 Breitwert Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: John A. Hoos

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 214 03 5906

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Helen H. Hoos

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1885

8. AGE: Years 63 | Months 1 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Retired Life Ins. Agent

11. Industry or business

FATHER
12. Name: John W. Hoos
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Annie Brandau
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Helen H. Hoos
(b) Address: 1916 Breitwert Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 20-48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Maryland

18 (a) Funeral director: Wm. Cook, Inc.
(b) Address: 1217 St. Paul Street, Md.

19 Date received by Registrar: FEB 18 1948

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH Feb. 17 1948, at 1:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 5 1948 to Feb 17 1948 and that I last saw h[illegible] alive on Feb 16 48

Immediate cause of death: Coronary occlusion — Duration: 10 days

Due to:

Due to: Cardiovascular disease — Duration: 9

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Geo. B. Kieffer M. D.

Address 2470 Broadway Blvd Date signed 2-17-48

VS 150

X

660294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 153

660294 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15-2
(c) Hospital or institution West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1921 West North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hilda Saunders

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Russell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1923

8. AGE: Years 25 | Months | Days | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Benjamin W Fox

FATHER 13. Birthplace Newyork

MOTHER 14. Maiden Name Dorf

MOTHER 15. Birthplace Russia

16 (a) Informant Russell Saunders

(b) Address 1921 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-18-48 (month) (day) (year)

(c) Cemetery or crematory Mount Montefiore

Location Washington Blvd

18 (a) Funeral director Jack Senn Inc

(b) Address 2400 Eutaw Place

19 (a) FEB 18 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-17 1948, at 7.29 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19 1948 to 2-17 1948, and that I last saw her alive on 2-17 1948

Immediate cause of death Acute Disseminated — Duration

Due to Lupus Erythematosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Berdinsky M. D.

Address We 4 Balto Gen'l Hosp Date signed 1-17-48

VS 150

X

660295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

660295 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2022 Linden ave
(c) Hospital or institution: 13-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No 2022 Linden ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Isaac Shapiro

3 (b) If veteran, name war

3 (c) Social Security Account No 215-01-6145

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Kebby

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 71 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Louis

13. Birthplace Russia

MOTHER 14. Maiden Name Minnie

15. Birthplace Russia

16 (a) Informant Kebby Shapiro

(b) Address 2022 Linden ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-18-48 (month) (day) (year)

(c) Cemetery or crematory Location Hebrew-Herring Run

18 (a) Funeral director Jack Kelvin Inc

(b) Address 2160 Eutaw Place

19 (a) FEB 18 1948 (Month, day, and year) (b) Signature for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-17-1948, at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 19 to 2/17 1948, and that I last saw him alive on 2/17 1948.

Immediate cause of death: Carcinoma of esophagus — Duration: 6mo

Due to: Obstruction of the heart duodenum — 2

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Irwin B Kass

Address 2320 Eutaw Pl Date signed 2/18/48

VS 150

X

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

660298 937 Registered No. 660296

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1034 W. Franklin St.
(c) Hospital or institution: 18-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1034 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLIFTON TORIAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
37			hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Anderson Torian
13. Birthplace N. C.

MOTHER
14. Maiden Name Belle Bonnett
15. Birthplace N. C.

16 (a) Informant Ambrose Torian
(b) Address 1119 Shields Pl.

17 (a) Burial (b) Date thereof Feb 20 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Cavalry
Location Baltimore

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

19 (a) [illegible] (b) Huntington Williams M.D.
(Undertaker or Key Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13, 1948 at 8.10 P M

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypostatic pneumonia Condition
Bronchial Spasm

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl K. Rose M.D.
Medical Examiner.
Date signed 2-14-48

660297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163 H

Registered No. 660297

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2-2
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 241 S. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara L Maddox

3 (b) If veteran, name war

3 (c) Social Security Account No. C 1280-95

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 7 1908?

8. AGE: Years	Months	Days	If less than one day
39	3	9	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Rittemeyer
13. Birthplace Germany

MOTHER
14. Maiden Name Lovas Thellanel
15. Birthplace Germany

16 (a) Informant Helen Byrnes
(b) Address 506 Curtain St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Edward Gaines
(b) Address 1359 Mc Henry Blvd

19 FEB 18 1948 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1948, at 2 45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection and Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Asphyxiation due to illuminating gas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-16-48 at ? P. M.
(b) Where did injury occur? 241 S. Broadway
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No (Explain in detail)
(d) Means of injury Asphyxiation by illuminating gas

23. Signature Carl L Kreyer M.D. Medical Examiner.
Date signed 2-17-48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660298

660298

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 212 Penn Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Magazine Foskey
3 (b) If veteran, name war
3 (c) Social Security Account No.
4 Sex Male
5 Color or race Colored
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Lizzora Foskey
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 4-10-96
8. AGE: Years 51 Months 10 Days 6 If less than one day hr. min.
9. Birthplace Portugal (Town, county and state)
10. Usual Occupation Dishwasher
11. Industry or business

FATHER
12. Name V. D. Foskey
13. Birthplace Portugal

MOTHER
14. Maiden Name
15. Birthplace Portugal

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 18 1948 (month) (day) (year)
(c) Cemetery or crematory Kinston N.C.
Location
18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Edmondson Ave
19 (a) FEB 18 1948 (Date filed by Registrar) (b) Baltimore Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-16 1948, at 4 M
21. I certify that death occurred on the date above stated; that I attended deceased from 2-3 1948 to 2-16 1948, and that I last saw M alive on 2-12 1948

Immediate cause of death: Acute Myocardial Infarction — Duration: Minutes / Hours / Days
Due to: Arteriosclerosis of the Coronary Arteries
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Aba

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Thomas J Hughes
Address Johns Hopkins Hospital Date signed 2-17-48

VS 150

X

660299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

Registered No. 660299

660299

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 1514 Division St.
(a) Baltimore City, Maryland
(b) Street address ~~1704 Ashland Ave~~
(c) Hospital or institution: Provident

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 Ashland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George W. Evans Sr.

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	N	Married

6 (b) Name of husband or wife: Wilhelmina A. Evans
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/16/1900

8. AGE: Years	Months	Days	If less than one day
47	5	29	hr. min.

9. Birthplace Sevierville, Tenn. (Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business

FATHER
12. Name Thomas Luther Evans
13. Birthplace East Pitt Tenn.

MOTHER
14. Maiden Name Mollie L. McMahon
15. Birthplace Sevierville Tenn.

16 (a) Informant George Pitt Evans Jr.
(b) Address 1504 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/48 (month) (day) (year)
(c) Cemetery or crematory Forbutus Memorial Park
Location

18 (a) Funeral director Robert L. Greene
(b) Address 1216 N. Caroline St.

19 FEB 18 1948 (Date received by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/15 1948 at 6 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/8 1948 to 2/15 1948 and that I last saw h[illegible] alive on 2/15 1948

Immediate cause of death [illegible]
Cirrhosis of liver — Duration

Due to

Due to

Other Conditions Acetonia
Gastro-Enteritis Hemorrhage
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. LeRoy Berry M. D.
Address 1430 E. Chase Date signed 2-15-48

VS 150

660300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

16

Registered No. 660300

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL 26-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1642 Rodman Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Jessee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-14-05

8. AGE: Years	Months	Days	If less than one day
42	11	3	hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Construction Worker

11. Industry or business

FATHER
12. Name Marshall Jessee
13. Birthplace Va

MOTHER
14. Maiden Name Sarah Castleberry
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 18 1948 (month) (day) (year)
(c) Cemetery or crematory
Location Bristol Tennessee

18 (a) Funeral director Henry W. Hankins & Son
(b) Address McCulloch Orchard Sts

19 (a) FEB 18 1948 (Date rec'd by registrar) (b) Huntington West Virginia

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-17- 1948, at 10 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-21- 1947 to 2-17- 1948, and that I last saw him alive on 2-17 1948.

Immediate cause of death	Duration
Tuberculous Meningitis	4 mos
Due to Rupture of Tuberculous Bronchial Gland	
Due to Operation for Resected with Pneumothorax	
Other Conditions intracerebral Disease Pneumonia, Left Lung (Include pregnancy within 3 months of death)	disease

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Victor A. McKusick M. D.
Address Huntington W Va Date signed 2/19/48

VS 150

X

G60301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48B

G60301 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 818 Sharp
(c) Hospital or institution: 22-V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 818 Sharp St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lola Watson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Albert Watson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec-14-1900

8. AGE: Years 47 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Wyatt Clark

13. Birthplace N. C.

MOTHER 14. Maiden Name Eliza

15. Birthplace N. C.

16 (a) Informant Odis Watson

(b) Address 818 Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-48 (month) (day) (year)

(c) Cemetery or crematory Portsmouth Location Va

18 (a) Funeral director James A. Davis

(b) Address 142 W. Bute St

19 (a) FEB 18 1948 (Date received by registrar) (b) Registrar

Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1948 at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-10 1947 to Feb-16 1948, and that I last saw him alive on Feb-16 1948.

Immediate cause of death Carcinoma of uterus

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Universal Hospital

of autopsy:

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Trauerstein M. D.

Address 1124 Lee V Date signed 2/17/48

C60302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

C60302

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2408 Montebello Terrace
(c) Hospital or institution: 27.3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2408 Montebello (If rural give location)
(e) Citizen of foreign country? Terrace (No) If yes, name country

3 (a) FULL NAME John Bibb ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Kate

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 4, 1877

8. AGE: Years: 70 | Months: 7 | Days: 11 | If less than one day: hr. min.

9. Birthplace: Louisa, Va (Town, county, and state)

10. Usual Occupation: Liveryman

11. Industry or business:

FATHER 12. Name: John Bibb
13. Birthplace: Orange, Va

MOTHER 14. Maiden Name: Elizabeth Coddon
15. Birthplace: Louisa, Va

16 (a) Informant: Mrs. Mary Thomas
(b) Address: 2408 Montebello Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2-16-1948 (month) (day) (year)
(c) Cemetery or crematory: Family Lot
Location: Louisa, Va

18 (a) Funeral director: Mrs. Geo. W. Hallam
(b) Address: 1651 Druid Hill Ave

19 (a) (Date received by registrar) FEB 18 1948 (b) Registrar

Huntington Hollins, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 15, 1948, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 25 1946 to Dec 15 1948 and that I last saw h[e] alive on Dec 15 1948

Immediate cause of death: Myocarditis — Duration: 1 mo.
Due to: Hypostatic Pneumonia — 13 months
Due to: non-union fracture Lt. femur
Due to: Arterio sclerosis
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, ~~suicide, or homicide~~: Fracture Rt. Ankle
(b) Date of occurrence: Dec 23, 1946 at 11 P. M.
(c) Where did injury occur? Piedmont (City or town) Randolph (County) W. Va. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? No While at work? No (Specify type of place)
(e) Means of injury: Fell from Truck
23. Signature: Jesse Hall M. D.
Address: 1621 N. Carey St.
Date signed: 2/18/48

For B. J. Davis, by Howard J. Mallis, M.D.

G60303 G79177 JL - 117304

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

54 B ✓ G60303 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 514 N. Pine St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wayman Matthews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1947

8. AGE: Years	Months	Days	If less than one day
	8	26	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Waters
13. Birthplace Md.

MOTHER
14. Maiden Name Allene Matthews
15. Birthplace Washington D. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-48 (month) (day) (year)
(c) Cemetery or crematory Burial
Location Mt. Calvary

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna Ave

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 18 1948 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 1948, at 12.55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 9 1948 to Feb. 14 1948, and that I last saw h im alive on Feb. 14 1948

Immediate cause of death	Duration
Brain Tumor	5 mos.
Due to	
Due to	over
Other Conditions Meningocele ? Hydrocephalus	5 mos.

(Include pregnancy within 3 months of death)
Date of operation Palliative 2 mos. ago
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gilligan P. Dufton M. D.
Address Balt City Hosp. Date signed 16 Feb '48

X

G60304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

180

G60304 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 6-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 Orleans St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES JONES, Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
1	16		hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Charley Jones
13. Birthplace Balto. Md
14. Maiden Name Dorothy Roberts
15. Birthplace Brooklyn N.Y.

16 (a) Informant Charles Jones
(b) Address 1709 Orlean St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 19. 48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brookley ave Baltimore, Md

19 FEB 18 1948 (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15, 1948, at 4.15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Suffocation from inhalation of smoke
Extensive first, second, and third-degree
Due to Burns.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 6/5
(a) Date of injury 2-15-48 at about 3.30 p.m.
(b) Where did injury occur? 1709 Orleans St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury House afire.

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 2-16-48

VS 151

C60305
GM. 107145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

C60305
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 18-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec. 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 510 & 512 N. Carrollton Ave (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Bothwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife Frank (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1-1890

8. AGE: Years	Months	Days	If less than one day
57	4	12	hr. min.

9. Birthplace MD. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Chapman (D)
13. Birthplace MD

MOTHER
14. Maiden Name Alice (D)
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-18-48 (month) (day) (year)
(c) Cemetery or crematory Suburban Memorial Park
Location Balt. County Md

18 (a) Funeral director Otho K. Barber
(b) Address 512 Carrollton Ave

19 (a) 1948 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-13-1948, at 8.40PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-28-1947 to 2-13-1948, and that I last saw her alive on 2-13-1948

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions Hypertensive Cardio-Vascular Disease. (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. T. Bamford M. D.
Address Balt. City Hosp. Date signed 2-14-48

Huntington Williams, M.D.

G60306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. G60306

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 237 S. East Ave.
(c) Hospital or institution: - - none - 26-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County - - -
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 237 S. East Ave. (If rural, give location)
(e) Citizen of foreign country? - No - (Yes or No)
If yes, name country - - - -

3 (a) FULL NAME James J. Carroll

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret M.
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 12-6-1873

8. AGE: Years 74 | Months 2 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Selling

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15 Birthplace

16 (a) Informant Margaret Carroll - wife
(b) Address 237 S. East Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-19-48 (month) (day) (year)
(c) Cemetery or crematory Glenn Haven
Location Annapolis Blvd

18 (a) Funeral director Lilly & Zeifer Inc
(b) Address 403 S. Wolfe St.

19 Filed FEB 18 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16, 1948 at 1:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to 2-16 1948, and that I last saw him alive on 2-16 1948.

Immediate cause of death	Duration
Coronary Thrombosis	1 hour
Due to Arteriosclerosis Cardiac Hypertrophy	
Due to Cardiac Decompensation	1 year
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thurlow Cooper
Address 2701 Eutaw Place Date signed M 2 D 18/48.

X

G60307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 B

G60307

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Liberty & Fairmount

(c) Hospital or institution: Church Home & Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days

(e) Length of stay in Baltimore (yrs., mos., or days) 14 days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County: Carroll

(c) City or town: Westminster

(If outside city or town limits, write RURAL and give town)

(d) Street No.: RFD #6

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME:** FRANCES M. BUCK

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife: Wilhemina Buck

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 11-1-1876

8. AGE: Years	Months	Days	If less than one day
71	3	19	hr. min.

9. Birthplace: Buckeye, Ohio (Town, county, and state)

10. Usual Occupation: Barber, retired

11. Industry or business:

FATHER

12. Name: Dilman Buck

13. Birthplace: Massachusetts

MOTHER

14. Maiden Name: Wilhemina Wheeler

15. Birthplace: Delaware

16 (a) Informant: Floyd Herbert Buck

(b) Address: Ellicott City, Md.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2-21-48 (month) (day) (year)

(c) Cemetery ~~or crematory~~: McKendree

Location: Cooksville, Howard Co. Md.

18 (a) Funeral director: C. M. Waltz

(b) Address: Union Mills. Md.

19 (a) FEB 18 1948 (b) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 February 1948, at 10:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5- 1948 to 2-18- 1948 and that I last saw him alive on 2-18- 1948.

Immediate cause of death: Uraemia - Renal failure — Duration: 3 weeks ±

Due to: Urinary Retention

Due to: Urethral structures

Other Conditions: Carcinoma of prostate (?)

(Include pregnancy within 3 months of death)

Date of operation: 2-12-48

Major findings of operation: Urethral structures

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature: D. P. Taylor M. D.

Address: Church Home Date signed: 2-18-48

VS 150

G60308

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 83a

Registered No. G60308

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hosp. 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 42 days
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 20
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6117 Berkley Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles R. Saylor

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/15/75

8. AGE: Years	Months	Days	If less than one day
72	4	3	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name — David R. Saylor
13. Birthplace — York, Pa.

MOTHER
14. Maiden Name — Elizabeth Abel
15. Birthplace — Pa.

16 (a) Informant Nephew (David P. Saylor)
(b) Address 242 Loch Raven Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-48 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill Cem.
Location York, Pa.

18 (a) Funeral director Wiedefeld & Son
(b) Address 6 Fremont Ave & 22nd St

19 (a) FEB 18 1948 (b)
(Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 1948, at 6:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/6 1948 to 2/18 1948 and that I last saw him alive on 2/18 1948.

Immediate cause of death Respiratory Failure — Duration

Due to Cerebral Accident

Due to Arteriosclerosis

Other Conditions Dry Gangrene Left Leg
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas P. O'Neill M.D.
Address St Joseph's Hosp Date signed 2/20/48

V S 150

660309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

660309 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 Hartman Ave.
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Meditz.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of husband or wife Joseph M. Meditz
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Oct 1, 1883

8. AGE: Years	Months	Days	If less than one day
64	4	17	hr. min.

9. Birthplace Titusville, Penna.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Bodamer
13. Birthplace Germany ?

MOTHER
14. Maiden Name Elizabeth Ford.
15. Birthplace Conneautville, Penna.

16 (a) Informant Joseph M. Meditz
(b) Address 8 Hartman Ave, Essex, Md

17 (a) Removal (b) Date thereof 2-18-40
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Katherines
Location Titusville Pa.

18 (a) Funeral director John B Connelly
(b) Address 115 Eastern Ave

19 (a) 1940 (b) Registered by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 1940, at 7:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1940, to Feb 18 1940, and that I last saw her alive on Feb 17 1940.

Immediate cause of death	Duration
Cardiac collapse	
Due to Toxemia	
Due to Metastatic Carcinoma, Rt. Breast.	
Other Conditions Hyperthyroidism.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury CARLTON GODLOVE

23. Signature [signature] M. D.

Address Hosp. for the Women of Md Date signed 2-18-40

VS 150

660310
JL - 117389

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

660310
Registered No. 1170

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 217 Marlyn Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius Gutensperger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Pauline
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1884

8. AGE: Years	Months	Days	If less than one day
63	8	26	hr. min.

9. Birthplace Switzerland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alfred
13. Birthplace Switzerland

MOTHER
14. Maiden Name Anna Shauk
15. Birthplace Germany

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 2-19-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave

18 (a) Funeral director John B Connelly
(b) Address 415 Eastern Ave

19 (a) [illegible] Washington Williams M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1948 at 1.45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1948, to Feb. 16 1948, and that I last saw h im alive on Feb. 16 1948

Immediate cause of death Cardiac failure + bronchopneumonia — Duration 2 hrs

Due to

Due to

Other Conditions 24 hr. post op after a subtotal gastrectomy

(Include pregnancy within 3 months of death)

Date of operation 2/14/48

Major findings of operation: Ulcer of gastric wall

of autopsy: Arteriosclerosis of heart & aorta etc.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gordon Craft M. D.
Address Balt City, Hosp. Date signed 2/16/48

X

60311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 60311

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Calvert
(c) City or town Westbeach
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Joseph Paddy

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/21/47

8. AGE: Years	Months	Days	If less than one day
	3	20	hr. min.

9. Birthplace Calvert Co. Hosp - Prince Frederick
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name James J. Paddy
13. Birthplace Washington, D.C.

MOTHER
14. Maiden Name Marilyn Elizabeth ??
15. Birthplace New Bedford, Mass.

16 (a) Informant James Paddy (father)
(b) Address West Beach, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 13 48 (month) (day) (year)
(c) Cemetery or crematory Mt Harmony Cem.
Location Nr. Owings, Md

18 (a) Funeral director W. H. Hutchins
(b) Address Owings, Md

19 (a) Feb. 13 1948 (b) Edgar L. Wentzel, M.D.
(Registrar's signature)
Huntingtown, Md.
(Address)
FEB 19 1948

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-11 1948, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2:15 P.M. 2-11 1948, to 4:45 P.M. 2-11 1948, and that I last saw him alive on 2-11 1948.

Immediate cause of death	Duration
Circulatory failure	—
Due to Meningitis, meningococcal	3 hrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David T. Karzon M.D.
Address Sydenham Hosp Date signed 11 Feb 48

G60312 693883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G60312

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 348 Dallas Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carol Jeanne Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 11-7-47

8. AGE: Years	Months	Days	If less than one day
	3	11	hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Otis A. Brown
13. Birthplace Queen Annes Co. Md

MOTHER
14. Maiden Name Irene B. Beauchamp
15. Birthplace Balto. Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location A.A. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 FEB 19 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-18- 1948, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16- 1948 to 2-18 1948 and that I last saw h[illegible] alive on 2-18- 1948.

Immediate cause of death: Atelectasis & Pneumonia — Duration 2 days
Due to: Type 16 Pneumococcus
Due to:
Other Conditions: Cong. Heart Disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Transmitted not Rec'd

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lyall Loyaught
Address Johns Hopkins Hosp. Date signed 2/19/48

Lyaughtx.

VS 150

C60313

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

C60313
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT
(c) Hospital or institution: MERCY HOSP 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 9 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 15 E. FRANCLIN ST.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ELMO F. MULLAN

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-12-8053

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
M	W	W

6 (b) Name of ~~husband or~~ wife Gertrude Mullan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 29, 1881

8. AGE: Years	Months	Days	If less than one day
66	6	20	hr. min.

9. Birthplace COLORADO
(Town, county, and state)

10. Usual Occupation PRINTER
11. Industry or business Southern Label & Box Co

FATHER
12. Name CHARLES X. MULLEN
13. Birthplace IRELAND

MOTHER
14. Maiden Name EMMA HUSTER
15. Birthplace MARYLAND

16 (a) Informant ADM. SLIP.
(b) Address

17 (a) Burial (b) Date thereof 2/21/48
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto, Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St.

19 (a) FEB 19 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB 18 1948 at 10 3-0 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/26 1948 to 2/18 1948 and that I last saw h/m alive on 2/18 1948

Immediate cause of death	Duration
CARDIAC AN RESPIRATORY FAILURE	
Due to CEREBROVASCULAR ACCIDENT (HEMORRAGE)	
Due to ARTERIO SCLEROSIS GENERALIZED.	
Other Conditions HYPERTENSION CONGESTIVE HEART FAILURE	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: CEREBRAL HEMORRAGE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elden H. Pentz M. D.
Address Mercy Hosp Date signed 2/18/48

VS 150

G60314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G60314

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Calvert Street
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 79 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1720 Bond St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Lusby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife: Stephen Lusby
6 (c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.) August 1869

8. AGE: Years	Months	Days	If less than one day
79	?	?	hr. min.

9. Birthplace: Calvert County
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Richard Wells
13. Birthplace: Calvert County

MOTHER
14. Maiden Name: Mary Trott
15. Birthplace: Unknown

16 (a) Informant: Niece
(b) Address: 1721 Winchester ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/48 (month) (day) (year)
(c) Cemetery or crematory: Lorraine
Location: Balto. Co. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.

19 (a) FEB 19 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 1948, at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 17 1948 to Feb 17 1948 and that I last saw h[illegible] alive on Feb 17 1948.

Immediate cause of death: Hyperglycemic Shock — Duration

Due to: Diabetes

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: L. M. Finnigan

Address: Mercy Hospital Date signed: Feb 17 1948

VS 139

X

660315 C92537 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 182a Registered No. 660315

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 936 N. Durham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cecilia M (Shock) Shock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) Oct 24th 1947

8. AGE: Years | Months 3 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name David M. Shock
13. Birthplace W. Va.

MOTHER 14. Maiden Name Viola M. Ewell
15. Birthplace Elliott Md.

16 (a) Informant David M. Shock
(b) Address 936 Durham St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/20/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Prospect Hill
Location Towson Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) FEB 19 1948 (Date rec'd by registrar) (b) ~~Hunting~~ for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1948, at 6 35 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Mechanical Suffocation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-18-48 at ? 7/4 A. M.
(b) Where did injury occur? 936 N. Durham St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? ~~no~~
(d) Means of injury Suffocated by bedclothes

23. Signature Earl A. Young M.D. Medical Examiner.
Date signed 2-18-48

VS 181

C60316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. C60316

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Genl Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2025 N. Calvert st. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE HENRY THOMAS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Mary S. Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 5th 1878

8. AGE: Years	Months	Days	If less than one day
69	11	12	hr. min.

9. Birthplace Titusville Pa. (Town, county, and state)
10. Usual Occupation Retired Supt.
11. Industry or business Apartment House

FATHER
12. Name Thomas
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary Becker
15. Birthplace Pa.

16 (a) Informant Geo. R. Thomas
(b) Address 2025 N. Calvert st.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 2/19/48 (month) (day) (year)
(c) ~~Cemetery or~~ crematory Greene Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) (Signature of local registrar) (b) Huntington for Williams M.D.

FEB 19 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17, 1948, at 8 22 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-13-1948 to 2-17-1948 and that I last saw h~~im~~ alive on 2-17-1948

Immediate cause of death Acute Pulmonary Edema — Duration

Due to Aortic Stenosis, Cardiac Enlargement — Duration

Due to Arteriosclerosis — Duration

Other Conditions Bilateral Lobar Pneumonia. Cyst Left Kidney — Duration
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Aortic Stenosis, Pulm. Edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Rubenstein M.D.
Address West Balto. General Hosp. Date signed 2/18

92a

G60317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c ✓

Registered No. G60317

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 513 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD R. CARES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) ~~Single, married, widowed, or~~ divorced. Divorced

6 (b) Name of ~~husband or~~ wife S. Blanche Cares

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24th 1884

8. AGE: Years 63 | Months 8 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

MOTHER / FATHER

12. Name Jacob Cares

13. Birthplace "

14. Maiden Name Anna "

15. Birthplace "

16 (a) Informant Robert E. Cares

(b) Address 2923 Edison Highway

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/20/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Parkwood

Location Parkville Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St

19 (a) FEB 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17, 1948, at 10.35 M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary thrombosis.

Pulmonary edema

~~Due to~~ Myocardial hypertrophy and degeneration.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George A. Merrill M.D. Medical Examiner.

Date signed 2-17-48

660318 Yetta Schaefer

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 660318

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-3
(e) Length of stay in Baltimore (yrs., mos., or days) 45

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2302 E. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Yetta Schaefer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Abe-

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Meyer Lazer-
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael-
15 Birthplace Russia

16 (a) Informant Abe Schaefer
(b) Address 2302 E. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-19-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jack Penza Inc
(b) Address 2100-02 Eutaw Place Huntington Williams, Mgr.

19 (a) FEB 19 1948 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18 1948, at 10 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1947 to 2/18 1948 and that I last saw her alive on 2/18 1948.

Immediate cause of death
Acute Bronchial Pneumonia
Due to Pulmonary Edema
Myocardial failure
Due to Chronic Nephritis
Other Conditions Cerebral Hemorrhage
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature A. A. Tornstein M. D.
Address 204 E. Biddle St Date signed 2/19/48

VS 150

G60319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G60319

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 W. Lafayette Ave.
(c) Hospital or institution: 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 W. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME REV. JOSEPH J. THOMAS

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Corlett H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1882

8. AGE: Years	Months	Days	If less than one day
65	8	27	hr. min.

9. Birthplace Calvert Co. Md. (Town, county, and state)
10. Usual Occupation Minister
11. Industry or business

FATHER
12. Name Lemuel Thomas
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Mary F. Freeland
15. Birthplace Calvert Co. Md.

16 (a) Informant Mrs. Corlett H. Thomas
(b) Address 506 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 19, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Jas. George A. Holland.
(b) Address 1631 Druid Hill Ave.

19 (a) FEB 19 1948 (Date rec'd by registrar) (b) Huntingtown, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15 1948, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1948 to Feb. 15 1948 and that I last saw h[illegible] alive on Feb 15 1948.

Immediate cause of death Diabetic Mellitus — Duration 2 yrs

Due to

Due to

Other Conditions Diabetic Coma — 5 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 1631 Druid Hill Ave. Date signed Feb 18 1948

VS 150

660320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 935

Registered No. 660320

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3815 Menlo Drive
(c) Hospital or institution:

27 - 20

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3815 Menlo Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Klioze

3 (b) If veteran, name war: World 1
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Celie Nee Greenberg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct, 23, 1895

8. AGE: Years	Months	Days	If less than one day
52	3	25	hr. min.

9. Birthplace: Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business: Tavern Business

FATHER
12. Name: Abraham Joseph Klioze
13. Birthplace: Poland

MOTHER
14. Maiden Name: Fannie Barron
15. Birthplace: Poland

16 (a) Informant: Irvin Klioze
(b) Address: 3815 Menlo Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb, 19, 1948 (month) (day) (year)
(c) Cemetery or crematory: Workme Circle Cemetery
Location: German Hill Road

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 (a) FEB 19 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION 5.30

20. DATE OF DEATH February 17 1948, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1947 19 to 2/17 1948, and that I last saw h[illegible] alive on 2/15 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 hr.
Due to: Intermittent Hypertension Cardio-Vascular Disease — Duration: 6 yrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Nathan B. Kirsch
Address: 232 W Eutaw Pl Date signed: 2/18/48

V S 150

Milton B. Kirsch

660321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164c

Registered No. 660321

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 25
(c) Hospital or institution: South Baltimore Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4106 Rowlet Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl F. Spangler

3 (b) If veteran, name war

3 (c) Social Security Account No. 200-05-4989

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Maried

6 (b) Name of ~~husband~~ or wife Ansley M Spangler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 30-1907

8. AGE: Years	Months	Days	If less than one day
40	1	19	hr. min.

9. Birthplace Penn.
(Town, county, and state)
10. Usual Occupation Rigger
11. Industry or business U. S. Coast Guard

FATHER
12. Name Arthur Spangler
13. Birthplace Penn.

MOTHER
14. Maiden Name Francis Dougherty
15. Birthplace Ireland

16 (a) Informant Mrs Ansley M Spangler
(b) Address 4106 Rowlet Court (25)

17 (a) Cremation (b) Date thereof 2/20/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Road

18 (a) Funeral director Milton Schilling
(b) Address 3914 Hanover St.

19 (a) FEB 19 1948 (b) Huntington Williamson, Mill
(Date received by registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18 1948, at 7 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of brain

Due to

Other Conditions Despondency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-18-48 at 6:40 P.M.
(b) Where did injury occur? Mr. 822 Jeffrey Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Firearm

23. Signature [signature] M.D.
Medical Examiner.
Date signed 2-18-48

660322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G60322

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1811 N. Smallwood street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 N. Smallwood street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME ROSE KAMMERER ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
---	---	Female	white	Widow

6 (b) Name of husband or wife William Kammerer
6 (c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.) Aug. 4, 1867

8. AGE: Years	Months	Days	If less than one day
80	6	13	____ hr. ____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name George Karl
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Henritz
15. Birthplace Germany

16 (a) Informant Mr. William A. Kammerer
(b) Address 1508 E. 33rd street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Thos. G. Evans & Son Inc.
(b) Address 1100 W. Mt. Royal Ave.

19 FEB 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1948 to Feb 17 1948, and that I last saw h alive on Feb 12 1948.

Immediate cause of death Cardiac Infarction — Duration about 5 days
Due to Bronchopneumonia — 10 days
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature G. Leslie Ewalt M. D.
Address 2945 St Paul St. Date signed 2/17/48

VS 150

660323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. 660323

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2028 Mt. Royal Terrace
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2028 Mt. Royal Terrace (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME William S. Austin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Elixabeth Fox

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1871

8. AGE: Years 76 | Months 6 | Days 24 | If less than one day hr. min.

9. Birthplace New York State (Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business

FATHER
12. Name James Austin
13. Birthplace N.Y.

MOTHER
14. Maiden Name Rhoda Smith
15. Birthplace N.Y.

16 (a) Informant Mrs. Elisabeth Fox Austin
(b) Address 2028 Mt. Royal Terrace

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 2/19/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John C. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 FEB 19 1948 (Date rec'd by registrar) Huntington Williams Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17, 1948 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1925 to Feb 17 1948.
and that I last saw h[illegible] alive on Feb 15 1948.

Immediate cause of death: Myocardial failure

Due to arterio sclerosis with hypertension

Due to —

Other Conditions Cerebral arterio-sclerosis

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: ✓

of autopsy: none

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence ✓ at M
(c) Where did injury occur? none (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? none While at work? none (Specify type of place)
(e) Means of injury none

23. Signature Chas. Sidbury Harrell M. D.
Address 710 Park Ave. Date signed

VS 150

97

T660324 QC. 480 1293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157B

Registered No. 660324

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County None
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4317 Sheldon Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Hartman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23, 1948

8. AGE: Years 0 | Months 0 | Days 26 | If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER / FATHER

12. Name Hartman, Mrs. Harry

13. Birthplace Virginia

14. Maiden Name Eve, Sylvia

15. Birthplace W. Va.

16 (a) Informant mother of deceased

(b) Address 4317 Sheldon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/48 (month) (day) (year)

(c) Cemetery or crematory Pinewood
Location Parkville, Md

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2008 Orleans St

19 (a) FEB 19 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18 1948, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 23 1948 to Feb. 18 1948, and that I last saw her alive on Feb. 18 1948.

Immediate cause of death	Duration
Meningitis - org. unknown	10 days
Due to Meningomyelocele	26 days
Due to Spina bifida	26 days
Other Conditions Paralysis of lower limbs, Generalized exfoliation	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

Same as clinical findings

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lee M. Howard M. D.

Address Church Home & Hosp. Date signed 2-18-48

VS 150

G60325

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G60325

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2312 E. Preston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2312 E. Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** John P. MacCubbin
3 (b) If veteran, name war
3 (c) Social Security Account No. 213-10-0371

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Katherine M. MacCubbin
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) July 20 1873

8. AGE: Years	Months	Days	If less than one day
74	6	28	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Baltimore Transit Co.

FATHER
12. Name Joshua MacCubbin
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary McAllister
15. Birthplace Baltimore Md.

16. (a) Informant Katherine M. MacCubbin
(b) Address 2312 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-20-48 (month) (day) (year)
(c) Cemetery or crematory Emmanuel Cem.
Location Loudon Park

18 (a) Funeral director John C. Miller Inc
(b) Address 2435 E. Pleasant St

19 (a) 2-19-1948 (Date received by Registrar) (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 1948 at 7.30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 1948 to Feb 17 1948 and that I last saw him alive on Feb 15 1948.

Immediate cause of death	Duration
Acute Dilatation of Heart	2 minutes
Due to Chronic Myocardial Insufficiency	6 years
Due to Arterial Sclerosis Cardiac	1 yr.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James Graham Manton M. D.
Address 614 Cathedral St Date signed 2-18-48

VS 150

G60326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

Registered No. G60326

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1831 N. Montford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Balto (b) County Md.
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1831 N. Montford Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Scheiffele

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-0909

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15th 1889

8. AGE: Years	Months	Days	If less than one day
59	1	2	hr. min.

9. Birthplace N. Y.
(Town, county, and state)
10. Usual Occupation Electric Typer
11. Industry or business Simpson's Dueller

FATHER
12. Name Frederich
13. Birthplace Germany.

MOTHER
14. Maiden Name Pauline Lehmidt
15. Birthplace Germany.

16 (a) Informant Mr. Edgar Slavinsky
(b) Address 1831 N. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 20th 1948 (month) (day) (year)
(c) Cemetery or crematory Trinity
Location Old Orangell St. East

18 (a) Funeral director Leo G. Leach
(b) Address 1111 N. Patterson Park Ave

19 (a) FEB 19 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17th 1948, at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1938, to FEB 16 1948, and that I last saw him alive on FEB. 16 1948.

Immediate cause of death	Duration
ARTERIOSCLEROSIS CORONARY ARTERY	10 years
Due to	
Due to	
Other Conditions CHRONIC BRONCHITIS	10 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Victor Goldberg M.D.
Address 3100 Harford Road Date signed Feb 18/48

VS 150

X

660327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1178

Registered No. 660327

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2813 Echodale Avenue
(c) Hospital or institution:
27-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2813 Echodale Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Augusta Frank

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Nicholas A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1864

8. AGE: Years	Months	Days	If less than one day
83	5	18	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

MOTHER / FATHER
12. Name Charles Zarnitz
13. Birthplace ?

MOTHER
14. Maiden Name Francisca Zarnitz
15. Birthplace ?

16 (a) Informant Mrs. George Frank
(b) Address 2813 Echodale Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) FEB 19 1948 (Date rec'd, month, day, year) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/17 1948, at 7 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 1946 to Feb 17 1948, and that I last saw her alive on 2/14 1948.

Immediate cause of death	Duration
Myocardial Failure	12 hours
Due to Arteriosclerotic heart disease	1½ years
Due to DIS ARTERIOSCLEROTIC GANGRENE of Rt LEG.	2 WEEKS
Due to PERIPHERAL VASCULAR ARTERIOSCLEROSIS	6 MOS
Other Conditions CHRON. DUODENAL ULCER	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John H. Hirschfeld M. D.
Address 919 Harford Rd Date signed 2/17/48

Hirschfeld 937

VS 150

BC - 48-03621

60328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 60328

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caroline St. 1213

(c) Hospital or institution: St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto.

(c) City or town Baltimore 13

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2504 E. Hoffman St.

(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) **FULL NAME** Louis Nelson Neff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/17/48

8. AGE: Years | Months | Days | If less than one day: 11 hr. 50 min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER

12. Name George H. Neff

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Margaret Vaughan

15. Birthplace Baltimore, Md.

16 (a) Informant Margaret Neff

(b) Address 2504 E. Hoffman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/48 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Balto.

18 (a) Funeral director L. J. Ruck

(b) Address 5305 Sidford Rd.

19 (a) FEB 19 1948 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/17/1948, at 3:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/17/1948 to 2/17/1948 and that I last saw him alive on 2/17/1948

Immediate cause of death: Respiratory Failure

Due to: Prematurity

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Anthony F. DiPaula, M.D.

Address St. Joseph's Hospital Date signed 2/19/48

V S 150

G60329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 153

Registered No. G60329

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3921 Wilkens Avenue
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3921 Wilkens Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lydia Pardoe

3 (b) If veteran, name war: no
3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Myrle L. Pardoe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1899

8. AGE: Years	Months	Days	If less than one day
45	7	15	hr. min.

9. Birthplace Pittsburg, Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business -

FATHER
12. Name Robert E. Stephan
13. Birthplace Germany

MOTHER
14. Maiden Name Eliza A. Francis
15 Birthplace Pittsburg, Pa.

16 (a) Informant Myrle L. Pardoe
(b) Address 3921 Wilkens Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 20-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland
Wm. Cook, Inc.

18 (a) Funeral director
(b) Address 1217 St. Paul Street, Baltimore

19 FEB 19 1948 Registered by registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18 1948, at 12:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29 1947, to Feb 18 1948, and that I last saw h[illegible] alive on Feb. 18 1948.

Immediate cause of death	Duration
Sclerodema	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sylvan A. Gerber M. D.
Address Medical Arts Bldg Date signed 2/19/48

VS 150

C60330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C60330

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3 N Streeper St

(c) Hospital or institution: 6-

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3 N Streeper St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arabell Burnes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widow

6 (b) Name of ~~husband~~ or wife Lib Alexander

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1, 1857

8. AGE: Years	Months	Days	If less than one day
90	4	15	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER

12. Name John Clark

13. Birthplace Baltimore Md

MOTHER

14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Mrs Lawrence Gelb

(b) Address 3 N Streeper St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/48 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel Cem

Location O'Donnell Road

18 (a) Funeral director John A Moran

(b) Address 3600 E Baltimore St

19 (a) FEB 19 1948 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1948, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 9 1948 to Feb. 16 1948, and that I last saw him alive on Feb. 16 1948.

Immediate cause of death Myocardial insufficiency

Due to senility, cachexia

Due to

Other Conditions hypostatic pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
✓ days
—

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature L. C. Schiled

Address 447 N. Kenwood Ave Date signed 2/19/48

VS 159

X

G60331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC-48-03923 / 159

Registered No. G60331

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital 27-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12d.
(e) Length of stay in Baltimore (yrs., mos., or days) 12d.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 534 Richmond ave. #12 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Schweitzer

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/6/48

8. AGE: Years	Months	Days	If less than one day
—	—	12 11	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business —

FATHER
12. Name Joseph B. Schweitzer
13. Birthplace Pata, Pa. USA

MOTHER
14. Maiden Name Helen B. McNally
15. Birthplace Penna.

16 (a) Informant Father
(b) Address 534 Richmond Ave. #12

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Feb 20 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Philadelphia Pa

18 (a) Funeral director John C Watson
(b) Address 3600 Baltimore St

19 (a) FEB 19 1948 (Date rec'd by registrar) **(b)** Huntington Williams, registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/17 19 48 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6 19 48 to 2/17 19 48 and that I last saw him alive on 2/17 19 48.

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jay Martin Fox M.D.
Address Union Memorial Hosp. Date signed 2/19/48

VS 150

660332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44B

Registered No. 660332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3903 Hudson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3903 Hudson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** WILLIAM C. DRANBAUER.

3 (b) If veteran, name war: World War I.

3 (c) Social Security Account No. 214-01-4188

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Agatha Dranbauer

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1899

8. AGE: Years 48 | Months 4 | Days 13 23 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Guard

11. Industry or business Standard Oil Co.

FATHER
12. Name August Dranbauer
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary Kafer
15. Birthplace Balto., Md.

16 (a) Informant Agatha Dranbauer
(b) Address 3903 Hudson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-48. (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location 7225 Eastern Ave.

18 (a) Funeral director Charles S. Zeiler.
(b) Address 901 S. Conkling St.

19 FEB 19 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17, 1948, at 2:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1946 to Feb. 17 1948, and that I last saw h[illegible] alive on Feb. 17 1948.:

Immediate cause of death: Acute Cardiac Failure.
Due to: Myocarditis & Decompensation.
Due to: Hodgkin's Disease.
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Edward A. Flannigan Jr. M. D.
Address 3503 Fait ave. Date signed 2/18/48

VS 150

X

660333

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH / 83a 660333

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1907 Presstman St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Isaac Henry Sidney

If U. S. Veteran specify WAR

(a) Residence: No. 1909 Presstman St., 15-2 Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Sidney

6. DATE OF BIRTH (month, day, year) 1886

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Driver

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) ~

11. Total time (years) spent in this occupation ~

12. BIRTHPLACE (city or town) Lancaster (State or country) Virginia

FATHER

13. NAME Parker Sidney

14. BIRTHPLACE (city or town) Lancaster (State or country) Virginia

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) Lancaster (State or country) Virginia

17. INFORMANT Mary Bradley

(Address) 1909 Presstman St

18. BURIAL, CREMATION, OR REMOVAL Burial

Place Arbutus Mem. Date 2/21 1948

19. UNDERTAKER Metropolitan Funeral Home Inc.

(Address) 921 N. Mount St.

FEB 19 1948

19. FILED 1948 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Feb. 16 1948

22. I HEREBY CERTIFY, That I attended deceased from Feb 4 1948 to Feb 16 1948

I last saw him alive on Feb 16 1948. Death is said to have occurred on the date stated above, at 9P m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	Feb 4
Other contributory causes of importance:	

Was an operation performed? No Date of

For what disease or injury? ~

Name of operation ~

What test confirmed diagnosis? Phy. Ex. Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ~ Date of injury ~ 19

Where did injury occur? ~ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury ~

Nature of injury ~

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) R. Garland Abercrombie M. D.

(Address) 1534 Druid Hill Ave

Case causes of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G60334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310 G60334 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Park Drive & 31st St.

(c) Hospital or institution: U. S. Marine Hospital 27-18

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days

(e) Length of stay in Baltimore (yrs., mos., or days) 41 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County -

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4815 Beauford Ave. Balto. Md. (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Juratovac, George Thomas (GEORGE THOMAS JURATOVAC)

3 (b) If veteran, name war - WW #1

3 (c) Social Security Account No. 218-10 - 5999

4. Sex: m

5. Color or race: w

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Katherine Hickman

6 (c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.) June 21, 1891

8. AGE: Years 56 | Months 8 | Days 16 | If less than one day: 24 hr. min.

9. Birthplace: Cleveland, Ohio (Town, county, and state)

10. Usual Occupation: Cook

11. Industry or business: Seafarer

FATHER 12. Name: George Juratovac

13. Birthplace: Austria

MOTHER 14. Maiden Name: Frances Zebode

15. Birthplace: Austria

16 (a) Informant: Records

(b) Address: U S Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/48 (month) (day) (year)

(c) Cemetery or crematory: Baltimore National

Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.

(b) Address: NORTH AVE. & BROADWAY

19 (a) FEB 19 1948 (Date filed by registrar) (b) Waiting for Williamsville, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 17, 1948, at 6:35AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7, 1948 to Feb. 17, 1948 and that I last saw h. im alive on Feb. 17, 1948.

Immediate cause of death	Duration
1- Hypertensive cardiovascular renal disease with cardiac failure and	Ten yrs.
Due to- uremia	
2- Pneumonia, bronchial, left	Few days
Due to lower lobe	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature: John L. Wilson, Sr. Surgeon M. D.

Address: U S Marine Hospital Date signed 2/17/48

VS 150

C60335 BALTIMORE CITY HEALTH DEPARTMENT C60335
Registered No.

CERTIFICATE OF DEATH 162 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1835 E. Lafayette Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(b) Street No. 1835 E. Lafayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNA PRAGEL

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	None	F	W	Widow

6 (b) Name of husband or wife Conrad Pragel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1865

8. AGE: Years	Months	Days	If less than one day
82	7	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Hartman
13. Birthplace Germany

MOTHER
14. Maiden Name Minna ?
15. Birthplace Germany

16 (a) Informant Mrs. Samuel Garnett
(b) Address 1835 E. Lafayette St

17 (a) Burial (b) Date thereof 2/20/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) 1948 (b)
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17 1948 at 9.30P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to 2/17 1948
and that I last saw h[illegible] alive on 2/17 1948.

Immediate cause of death	Duration
Cerebral Embolism	1 hr
Due to Hardening of Arteries	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Hugh H. Sadler M. D.
Address 3323 E. Balto St Date signed 2/19/48

vs FEB 19 1948

X

G60336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G60336

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2107 Sinclair Lane

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 - 2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

Street No. 2107 Sinclair Lane

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME JOSEPH HENRY CARLIN

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	218-09-7941	M	W	Widowed

6 (b) Name of husband or wife Emily Jane (Nelson)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 24, 1855

8. AGE: Years	Months	Days	If less than one day
92	11 10/16	21 1/2	hr. min.

9. Birthplace Frederick, Maryland

(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Citizens Savings Bank

FATHER

12. Name Joseph Carlin

13. Birthplace Maryland

MOTHER

14. Maiden Name Sarah Getzendanne

15 Birthplace Maryland

16 (a) Informant Miss Florence I. Carlin

(b) Address 2107 Sinclair Lane

17 (a) Burial (b) Date thereof 2/20/48

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel Cemetery

Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.

(b) Address NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) Washington Wm. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17 1948, at 3.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from February 12 1948 to February 17 1948.

and that I last saw h alive on February 17 1948.

Immediate cause of death 1 Cardiac Dilatation

Duration 2 days.

Due to Myocardial Insufficiency

Duration 1 year.

Due to Arterial + Cerebral - Arteriosclerosis

Duration 5 years.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence. at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Albert Eisenberg

Address 2035 E North Ave Date signed 2-18-48

VS 150

FEB 20 1948

X

G60337 GM. 117524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/12 B

G60337 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 5-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 N. Exeter ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward J. Mc Ginn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	D

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb, 7- 1884

8. AGE: Years	Months	Days	If less than one day
64		11	hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 21, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Balto Co

18 (a) Funeral director J. B. M. Wallace
(b) Address Pratt & Stricker Sts

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

FEB 19 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-18-48 1948, at 1.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-17- 1948, to 2- 18 - 1948, and that I last saw h im alive on 2- 18 - 1948.

Immediate cause of death	Duration
Pulmonary Intercalus	2
Due to	
Due to	
Other Conditions Hypertensive Cardiovascular Disease. (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. T. Bamford M. D.
Address Balt. City Hosp. Date signed 2-18-48

X

C60338

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

C60338 Registered No. 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore & Carey Sts.
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-1
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore (If outside city or town, limits write RURAL and give town)
(c) Street No. 332 N. Smallwood (If rural give location)
(d) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES SWITZER

3 (b) If veteran, name war WORLD WAR ONE
3 (c) Social Security Account No.
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Unknown
8. AGE: Years 59 Months Days If less than one day hr. min.
9. Birthplace Baltimore, Md (Town, county and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Ester Ladow
(b) Address 332 N. Smallwood St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew Cem
Location 5554 Reisterstown Ave
18 (a) Funeral director John Lowman & Son
(b) Address 901-03 N. Wolfe St.
19 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/16/48 19 8:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerosis Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Evans M.D.
Medical Examiner.
Date signed 2/17/48

VS 151

C50339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. C50339

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 410 N. Carrollton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 N. Carrollton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Belle Haggins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Married

6 (b) Name of husband or wife John Haggins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 8 1909

8. AGE: Years	Months	Days	If less than one day
38	6	8	hr. min.

9. Birthplace Sharon S.C.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Steven McDowell
13. Birthplace Laurinville S.C.

MOTHER
14. Maiden Name Lelia Byrd
15. Birthplace Sharon S.C.

16 (a) Informant Lelia Sparks
(b) Address 419 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 20, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 W. Lexington St.

19 (a) FEB 19 1948 (b) [illegible] Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948, to Feb 16 1948, and that I last saw h[illegible] alive on Feb. 15 1948.

Immediate cause of death.	Duration
Metastatic Carcinomatosis.	
Due to Carcinoma of Breast.	3 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jas. S. Duligan M. D.
Address 5 W. Lexington St. Date signed 2/19/48.

C60340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. C60340

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 713 N. Mount St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 - 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 N. Mount.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Peale

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Widow

6 (b) Name of husband or wife Lucy T. Peals
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 15 1875

8. AGE: Years	Months	Days	If less than one day
73	1	5	hr. min.

9. Birthplace Howard Co Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Robert Peal
13. Birthplace Md.

MOTHER
14. Maiden Name Annie ?
15. Birthplace Howard Co. Md

16 (a) Informant Jerry Brown
(b) Address 713 Mount St

17 (a) Burial (b) Date thereof Feb. 19, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Lotus Memorial
Location

18 (a) Funeral director Mrs Kate R Williams
(b) Address 329 N. Schroeder St.

19 (a) FEB 19 1948 (b)
(Date rec'd by registrar) Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1948 at 6 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 20 1947 to Feb 15 1948
and that I last saw h. alive on Feb 15 1948

Immediate cause of death Acute congestive Heart Failure; C Pul Edema — Duration 6 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Harland Schnauf Jr

Address 602 W. Franklin Date signed Feb 17 48

Hilton Williams, M.D.

660341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓937

660341 Registered No.

PLEASE PRINT, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 109 S. Stockton Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THEODORE MACKAY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Lucy Mackey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1894

8. AGE: Years	Months	Days	If less than one day
53	5	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Moses Mackey
13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Elizabeth
15. Birthplace Md.

16 (a) Informant Helen E. Yancey
(b) Address 927 W. Lafayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 19, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 322 N. Schroeder St

19 (a) FEB 19 1948 (Date rec'd by registrar) (b) Huntington Williams, MD Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15, 1948, at 10.50 P M

21. I certify that I took charge of the remains described above, held an insp.& inq. Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive Cardio-
Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earle Ross M.D.
(Medical Examiner.)
Date signed 2-16-48

X

C60342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. C60342

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3706 Fortonia Road

(c) Hospital or institution: Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 20

(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2013 W. Pratt Street

(If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Carl Henry Zirkler

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Anna Zirkler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17 1861

8. AGE: Years	Months	Days	If less than one day
86	7	1	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

MOTHER FATHER

12. Name Carl Zirkler

13. Birthplace Germany

14. Maiden Name Unknown

15. Birthplace Germany

16 (a) Informant Sophia A. Thurnwald

(b) Address 2013 W. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 20-1948 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore Md

18 (a) Funeral director George E. Schmidt

(b) Address 2101 Frederick Ave

19 (a) FEB 19 1948 (Date received by registrar) (b) Burial Permit Issued

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18 1948, at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1947 to Feb. 1948 and that I last saw him alive on Feb. 16 1948

Immediate cause of death	Duration
Cardiac failure	
Due to Auricular fibrillation	
Due to Arteriosclerosis	
Other Conditions Broncho-Pneumonia, Benign Prostatic Hypertrophy	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature L. Krulewitz M. D.

Address 2116 W. Pratt St Date signed 2/19/48

VS 150

98

G60343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V131a

Registered No. G60343

The information should be carefully supplied. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27
(c) Hospital or institution: MARYLAND GENERAL HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5621 CLEARSPRING RD.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. ESTHER E DAVIS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, Married, Widowed, or Divorced
F	W	MARRIED

6 (b) Name of husband or wife GEO. N. DAVIS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 6/15/1915

8. AGE: Years	Months	Days	If less than one day
32	8	4	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation CLERICAL
11. Industry or business DAVIS & OSBORNE CO.

FATHER
12. Name ARTHUR LEHMAN
13. Birthplace GERMANY

MOTHER
14. Maiden Name MINNIE CHRISTENS
15. Birthplace (Maiden) BALTIMORE, MD.

16 (a) Informant HUSBAND
(b) Address SAME

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/21/48 (month) (day) (year)
(c) Cemetery or crematory
Location ST. PAULS, VIOLETVILLE

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTIMORE MD

19 (c) Date rec'd 2-19-1948 Registrar Remington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 1948 at 4:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-24 1948 to 2-19 1948 and that I last saw her alive on 2-18 1948

Immediate cause of death	Duration
RESPIRATORY FAILURE	
Due to UREMIA	
Due to CHRONIC NEPHRITIS	
Other Conditions HYPERTENSION	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. L. Monow Jr. M. D.
Address Md. L. Hosp. Date signed 2-19-48

G60344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G60344

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto., #16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3708 Clifton Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Earle Blackburn Wellener

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Mrs. Lola Wellener
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1884

8. AGE: Years	Months	Days	If less than one day
63	3	21	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Retired - CHIEF CLERK
11. Industry or business FEDERAL LAND BANK

FATHER
12. Name William C. Wellener
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Blackburn
15. Birthplace Md.

16 (a) Informant MRS. EDWIN LOWE
(b) Address 2140 Mt. Holly St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/21/48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PK.
Location BALTIMORE, MD.

18 (a) Funeral director Wm. T. TICKNER & SON
(b) Address BALTIMORE, MD.

19 (a) FEB 19 1948 (Date rec'd by registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/18/48 19 , at 6:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/12 1948 to 2/18 1948 and that I last saw him alive on 2/18 1948

Immediate cause of death Acute congestive heart failure & pulmonary edema — Duration

Due to Coronary sclerosis

Due to Arteriosclerotic heart disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Richard Bowers M. D.
Address Union Memorial Hospital Date signed 2/18/48

VS 150

X

C60345

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 469

Registered No. C60345

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24da.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1500 N. Spring St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Martin Gavin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Anna T. Tillhof
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/6/84

8. AGE: Years	Months	Days	If less than one day
63	6	9 10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Baker
11. Industry or business

FATHER
12. Name John M. Gavin
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Ann Canton
15. Birthplace Balto. Md.

16 (a) Informant Anna T. Gavin
(b) Address 1500 N. Spring Ave.

17 (a) Burial (b) Date thereof 2/20/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Good Shepard
Location Howard Co.

18 (a) Funeral director C. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) FEB 19 1948 (b) Registrar
(Date received by Registrar)

S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 Feb 1948, at 7 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/23 1948 to 2/16 1948 and that I last saw h[illegible] alive on 2/16 1948.

Immediate cause of death	Duration
(a) Carcinoma body of pancreas	
Due to (b) with carcinomatosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E. Mays
Address 1400 N. Caroline Date signed 2/19/48

Burington for Millersville, Md.

37

X

G60346

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

Registered No. G60346

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St. 10
(c) Hospital or institution: Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Della) Bridget Coop

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	W.

6 (b) Name of husband or wife Joseph Coop (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) No exact knowledge

8. AGE: Years	Months	Days	If less than one day
about 76 "			hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Brennan
13. Birthplace

MOTHER
14. Maiden Name Mary McGrath
15. Birthplace

16 (a) Informant Sister of the Poor
(b) Address 1200 Valley St.

17 (a) Burial (b) Date thereof Feb 21, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wendfeld
(b) Address 700 East Biddle St

FEB 19 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15 1948, at 1:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 - 1948, to Feb 16 1948, and that I last saw h[illegible] alive on Feb 16 - 1948.

Immediate cause of death — Duration
Carcinomatosis — 1 month
Due to
Carcinoma Rt Breast — 1 yr.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E North Ave Date signed 2/19/48

Permit for Williams, Registrar

VS 150

X

G60347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G60347

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County Wicomico
(c) City or town Fruitland
(If outside city or town limits, write RURAL and give town)
(d) Street No. near Salisbury
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jeannette Smith / Jeanette Florence Smith. /

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Wm. Marion Smith
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1901

8. AGE: Years	Months	Days	If less than one day
47	1	1	hr. min.

9. Birthplace Wicomico County Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business None

FATHER
12. Name Quinton Hammond
13. Birthplace Md.

MOTHER
14. Maiden Name Henrietta Parkard
15. Birthplace Md.

16 (a) Informant Wm. Marion Smith
(b) Address Box 64 Fruitland Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/48 (month) (day) (year)
(c) Cemetery or crematory Salisbury ~~Local~~
Location Salisbury Md.

18 (a) Funeral director Holloway & Co.
(b) Address Salisbury Md.

19 (a) (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 1948, at 4:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/22 1948 to 2/19 1948, and that I last saw her alive on Feb. 19 1948.

Immediate cause of death Respiratory & Circulatory Collapse — Duration
Due to Massive Pulmonary Embolism
Due to Thrombosis of Pelvic Veins
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation Carcinoma of Rectum
of autopsy same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sidney H. Sachs M.D.
Address University Hosp. Date signed 2/19

VS 150

660348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

Registered No. B 60348

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County U. S. A. Carroll
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. Taneytown, Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Miss Abbie Fogle

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single

(b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 24, 1876

8. AGE: Years 71 | Months 11 | Days 26 | If less than one day hr. min.

9. Birthplace Carroll Co., Md.
(Town, county, and state)

10. Usual Occupation Factory worker

11. Industry or business Clothing factory

FATHER
12. Name George Fogle (dec.)
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Fogle (dec.) (Fleagle)
15. Birthplace Md.

16 (a) Informant Records
(b) Address St. Agnes Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 28, 1948 (month) (day) (year)

(c) Cemetery or crematory Lutheran Cemetery
Location Taneytown, Md.

18 (a) Funeral director C. O. Fuss & Son
(b) Address Taneytown Md.

19 (a) 3-3-1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19, 1948, at 9:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-14 1948 to 2-19 1948
and that I last saw her alive on 2-19 1948.

Immediate cause of death	Duration
Cardiac failure - Cachexia -	
Due to Severe anemia secondary to hematuria -	
Due to Generalized carcinomatosis	
Other Conditions Ca. of gall bladder (on liver) ? Uremia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sidney J. Venable Jr. M. D.
Address St. Agnes Hospital Date signed 2-19-48

660349 HL. 116861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 660349

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospital 20-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1831 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1882

8. AGE: Years	Months	Days	If less than one day
66 65	-	10	hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Avenue

17. Burial Final (Burial, cremation, or removal) (b) Date thereof 2/23/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore MD

18 (a) Funeral director Wilson Cook Inc
(b) Address 1219 E Cold St

19 (a) 660 2-20-48 (Registered number) (b) Huntington Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19, 1948, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 24 1948 to Feb. 19 1948, and that I last saw him alive on Feb. 19 1948

Immediate cause of death ? Cardiac infarction — Duration

Due to Arteriosclerotic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. T. Bruford M. D.
Address Balt. City Hosp. Date signed 2-19-48

VS 150

660350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 109a

660350 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light Street

(c) Hospital or institution: South Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) ?

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1604 Hazel Street (If rural give location)

(e) Citizen of foreign country? , (Yes or No) If yes, name country

3 (a) FULL NAME John Levenski

3 (b) If veteran, name war ?

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Frances

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1881

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation ?

11. Industry or business Bethlehem Steel Co.

FATHER
12. Name ? Levenski
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Sabina Ozdarski

(b) Address 1604 Hazel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/48 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location a.a.c. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

19 (a) FEB 20 1948 (Date rec'd by registrar) (b) Hunting for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 1948, at 4:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 14 1948 to Feb. 14 1948 and that I last saw him alive on Feb. 14 1948.

	Duration
Immediate cause of death Respiratory Failure	2 min.
Due to Multiple lung abscesses (Cl.) and diffuse pneumonitis	1 day
Due to Friedlander's bacillus	
Other Conditions Bronchiectasis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. D. Coates M.D.

Address 1213 Light St. Date signed 2/19/48

VS 150

X

660351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164a

660351 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27-17
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 343 Rosebank Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME OSCAR H. STRANGE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Florence A. Stange
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Mar. 11th 1888

8. AGE: Years	Months	Days	If less than one day
59	11	8	..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Oscar F. Stange
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Von Linzen
15. Birthplace Germany

16 (a) Informant Fred W. Stange
(b) Address 343 Rosebank Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/21/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) FEB 20 1948 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19, 1948, at 4.55 a M

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, ~~suicide~~ ☑ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Strangulation due to Hanging

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-19-48 at 4.15 a. M.
(b) Where did injury occur? Northern Police -cell. Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Hang self with belt in cell.

23. Signature [signature] M.D. Medical Examiner
Date signed 2-19-48

X

60352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 60352

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1615 Poplar D.O.A. 25.5
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Poplar St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas A. Hamilton

3 (b) If veteran, name war W. W. #1

3 (c) Social Security Account No. 170-18-9844

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
M	W	Married

6 (b) Name of ~~husband or wife~~ Grace Hamilton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6th 1895

8. AGE: Years	Months	Days	If less than one day
52	5	13	hr. min.

9. Birthplace 2 (Town, county, and state)

10. Usual Occupation Guard

11. Industry or business Maritime Commission

FATHER
12. Name Hamilton
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Grace Hamilton
(b) Address 1615 Poplar st

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/20/48 (month) (day) (year)
(c) Cemetery or crematory Holsinger
Location Roaring Spring Pa

18 (a) Funeral director William Coughlin
(b) Address 1217 Fort Ave

19 (a) FEB 20 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/19 1948, at 5:30 P.M.

21. I ~~certify~~ that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said ~~Autopsy~~, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. F. Schmidt M.D. Medical Examiner.
Date signed 2/19/48

VS 151

G60353

BC-48-05541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G60353

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette and Gilmore Sts.
(c) Hospital or institution:
Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Lansdowne - 27 Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2409 Hammonds Ferry Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Harris

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) February 7, 1948

8. AGE: Years	Months	Days	If less than one day
—	—	1	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Newborn
11. Industry or business —

FATHER
12. Name Wilmer Richard Harris, Jr.
13. Birthplace Lansdowne Md.

MOTHER
14. Maiden Name Jeanne Magdelene Galbreath
15. Birthplace Lansdowne, Md.

16 (a) Informant Mrs. Wilmer Harris
(b) Address Lansdowne, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location Johns Hopkins Medical School FEB 10 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 20 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 Feb. 1948 at 12:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7 Feb 1948 to 8 Feb 1948 and that I last saw her alive on 8 Feb 1948.

Immediate cause of death — Duration

Due to Atelectasis.

Due to prematurity.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Reed Maxwell
Address Franklin Square Hospital Date signed 9 Feb

VS 186

G60354

BC. 48 · 03473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161 C

Registered No. G60354

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 819 N. Fulton Ave
(c) Hospital or institution: 16-3
(d) Length of stay in hospital or inst. (~~yrs.~~, ~~mos.~~, or days) 2
(e) Length of stay in Baltimore (~~yrs.~~, ~~mos.~~, or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 819 N. Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Potilla

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married~~, ~~widowed~~, or ~~divorced~~
Male	C.	

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/8/48

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Gordon Gaskins
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Doris Muriel Potilla
15. Birthplace Baltimore, Md.

16 (a) Informant Doris M. Potilla
(b) Address 819 N. Fulton Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 11 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-10 1948 at 9:04 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-8 1948 to 2-10 1948 and that I last saw him alive on 2-10 1948

Immediate cause of death Pulmonary Edema — Duration 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice Lilly, M. D.

Address 1543 Eutaw Pl. Date signed 2/10/48

V S 150

X

660355

BALTIMORE CITY HEALTH DEPARTMENT

B- 48-02528 CERTIFICATE OF DEATH 160a

660355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 17-1
(b) Street address
(c) Hospital or institution: UNIVERSITY HOSPITAL
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 3
(e) Length of stay in Baltimore (~~yrs., mos., or~~ days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 N. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl MILLS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race COL

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-26-48

8. AGE: Years | Months | Days 3 | If less than one day hr. min.

9. Birthplace UNIVERSITY HOSPITAL
(Town, county, and state)

10. Usual Occupation INFANT

11. Industry or business

FATHER
12. Name BOBBIE LEE MILLS
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name ALDEAN MILLS
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School FEB 6 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 20 1948 (Date) Huntington Williams M.D. (Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-29 1948, at 12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-26 1948 to 1-29 1948.
and that I last saw her alive on 1-29 1948.

Immediate cause of death ~~INTRACRANIAL H.G.HAEMORRHAGE~~ ASPHYXIA — Duration ~~3 DAYS~~ 3 DAYS

Due to INTRACRANIAL HEMORRHAGE — 3 DA.

Due to

Other Conditions NEONATAL STATE
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edw. L. Leeman M.D.
Address University Hosp. Date signed 2/4/48

660356

BC: 48-02322

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

660356
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 133
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2325 McCulloh St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Young
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 DAYS

8. AGE: Years | Months | Days 2 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER
12. Name Leroy Young
13. Birthplace
14. Maiden Name Octavia Young
15. Birthplace

16 (a) Informant Ricardo
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 9 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 20 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1948, at 3 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1948 to Feb 5 1948, and that I last saw h. alive on Feb 5, 1948.

Immediate cause of death	Duration
Prematurity	2 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel Lyons M.D.
Address Johns Hopkins Hosp Date signed Feb 6 1948

VS 150

660357

B-60357

BC-48-06058

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

660357
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24.3
(c) Hospital or institution: SOUTH BALTIMORE GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 Light Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSALIE G. LUDWIG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 13 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1948, at 6 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Prematurity.
Edema of lungs.
Acute tracheobronchitis.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 2-5-48

X

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G60358 O'CONNOR ✓ G60358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 829. S. Bond St.
(c) Hospital or institution: 2-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 829. S. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Oconnor

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 182-09-2843

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ wife Maria Oconnor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2. 1893.

8. AGE: Years	Months	Days	If less than one day
54 5-5.	10	15	hr. min.

9. Birthplace New York. N.Y. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace New York. N.Y.

MOTHER
14. Maiden Name Unknown
15. Birthplace New York. N.Y.

16 (a) Informant Maria Oconnor
(b) Address 829-S. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 20. 1948. (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Washington Boulevard

18 (a) Funeral director Weddell & Hyppel
(b) Address 3128 - Neighborhood Ave

19 FEB 20 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 1948 at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1947 to Feb 17 1948. and that I last saw h~~im~~ alive on 2/17 1948

Immediate cause of death Coronary Thrombosis — Duration 1½ hrs.
Due to arteriosclerosis — 2
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. J. Jenkins M. D.
Address 100 N Milton Ave Date signed 2/19/48

VS-150

X

660359 HL 112918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 13B

Registered No. 660359

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospital 12-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5mos. 17days
(e) Length of stay in Baltimore (yrs., mos., or days) 32 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2105 St. Paul St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Doris Alligood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Bardon F. Alligood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1915

8. AGE: Years	Months	Days	If less than one day
32	7	22	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Leland Frazier Woolard
13. Birthplace N.C.

MOTHER
14. Maiden Name Emma V. Deal
15. Birthplace MD.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 20 1948 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto Md

18 (a) Funeral director Henry W. Jenkins & Son
(b) Address McCulloh & Orchard Sts

19 (c) FEB 20 1948 (Date rec'd by registrar) (Huntingtown, Williamsport, Md.)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18, 1948, at 3-58 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-11-47 19 47 to 2-18 19 48 and that I last saw him alive on 2-18 19 48

Immediate cause of death Pulmonary tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. T. Bonfard M. D.
Address Balt. City Hosp. Date signed 2-18-48

X

G60360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 13B

G60360 Registered No.

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 3-1
(a) Baltimore City, Maryland
(b) Street address D.C.H.
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 E. Preston (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Cruenbeck

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 13 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 20 1948 (Date rec'd by registrar) Washington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6 1948 at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary TBC

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 2/9/48

X

C60361

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

Registered No. C60361

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 E. Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 - Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME PETE TAILFER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 71 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School FEB 13 1948
Location

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 20 1948 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-27 1948, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-16 1948, to 1-27 1948, and that I last saw h[illegible] alive on Jan 24 1948.

Immediate cause of death Generalized Carcinomatosis — Duration 1 month

Due to Carcinoma of Rectum — 2 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R. Klemm
Address 3803 Edmondson Ave. Date signed 1/27/48 M.D.

VS 180

G60362 JL - 99109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G60362

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 26-17
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2400 Gilmor St. ?
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Carol
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
70 ?			hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Grass Croxton
13. Birthplace Md.

MOTHER
14. Maiden Name Eliza Wormly
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 2 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 2 1948 (Date received by registrar) (Signature) Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION AM

20. DATE OF DEATH Jan. 17 1948, at 1.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7 1946 to Jan. 17 1948, and that I last saw her alive on Jan. 17 1948

	Duration
Immediate cause of death Cardiac Failure	
Due to Hypertensive Cardiovascular Disease	yrs.
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy: No	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. E. Coburn Jr. M. D.
Address Balt. City Hosp. Date signed 1/28/48

C60363 State Anatomical

BALTIMORE CITY HEALTH DEPARTMENT ✓ C60363
Registered No.

CERTIFICATE OF DEATH 30E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 173
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 725 N. Fremont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Rowe.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-5-86.

8. AGE: Years	Months	Days	If less than one day
61	8	26	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Cook.
11. Industry or business

FATHER
12. Name George Rowe.
13. Birthplace "

MOTHER
14. Maiden Name Mary "
15. Birthplace "

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location University Medical School FEB 11 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 FEB 20 1948 (Date filed by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1 1948, at 8.30 M P

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 31 1948, to Feb 1 1948, and that I last saw him alive on Feb. 1 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Arterial Hypertension	
Due to	
Other Conditions Syphilis Hunt Disease	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy Autopsy Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irby Stephens
Address Johns Hopkins Hosp. Date signed 2/2/48 M D

VS 150

83a

G60364 BC-48-02744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 153

Registered No. G60364

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24 S Potomac St
(c) Hospital or institution: Maryland General Hospital 1-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 24 S Potomac St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** KENNETH KAUFMAN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	S

6 (b) Name of husband or wife 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1948

8. AGE: Years	Months	Days	If less than one day
		16	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Henry Kaufman
13. Birthplace Baltimore

MOTHER
14. Maiden Name Virginia A. Schaumann
15. Birthplace Baltimore

16 (a) Informant Henry Kaufman
(b) Address 24 S. Potomac St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North ave. & Rose St

18 (a) Funeral director Laurence F. Hoffmann
(b) Address 1639 Broadway

19 FEB 20 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 1948, at 6.00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 17 1948, to Feb. 19 1948, and that I last saw him alive on Feb. 19 1948.

Immediate cause of death	Duration
Cardio-respiratory Failure	15 minutes
Due to Dehydration	3 days
Due to Acute exfoliative dermatitis, generalized, c.u.	8 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Feb. 19, 1948

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alfred N. Dann, M.D.
Address Maryland General Hosp. Date signed 2/19/48

VS 153

X

Type or print, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C60365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C60365

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident 16-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 408 Carson Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES LABSITER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School FEB 18 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (d) FEB 20 1948 (Date rec'd by registrar) (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9/48 19 at 3.30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D. (Medical Examiner)
Date signed 2/10/48

VS 151

X

CAUTION: ANY ALTERATION, WITH ERASING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

660366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 660366

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 4-1
(b) Street address
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - Health Mission (If outside city or town limits, write RURAL and give town)
(d) Street No. 611 E. Baltimor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK STAHL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical School FEB 18 1948

18 (a) Funeral director Commissioner of Health

(b) Address

FEB 20 1948 (Date Rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8 1948, at 11.10 a M

21. I certify that I took charge of the remains described above, held an insp.& inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature per Dr. Wm. M. Kamer. M.D. (Medical Examiner)

Date signed 2-9-48

G60367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G60367

107

Please write plainly, with unfading ink. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4800 York Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass. (b) County
(c) City or town Boston
(If outside city or town limits, write RURAL and give town)
(d) Street No. Children's Hospital
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Christopher Borror

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 22, 1947

8. AGE: Years | Months: 3 | Days: 25 | If less than one day: hr. min.

9. Birthplace Boston, Mass.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Christopher Smith
13. Birthplace Elgin, Illinois

MOTHER
14. Maiden Name Martha Borror
15. Birthplace Amarillo, Texas

16 (a) Informant Mrs. Margaret Borror
(b) Address Amarillo, Texas

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 18 1948

18 (a) Funeral director Commissioner of Health

(b) Address

FEB 20 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15 1948, at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1948 to Feb 15 1948, and that I last saw him alive on Feb. 12 1948.

	Duration
Immediate cause of death: Aspiration Pneumonia	1 day
Due to: Prematurity	
Due to:	
Other Conditions: Malnutrition	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gibson J. Wells M. D.

Address 3222 St. Paul St. Date signed Feb. 16, 48

VS 159

660368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 660368

660368

To insure, with ONE ENTRY, Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 811 W. Lombard St
(c) Hospital or institution: 18-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) About 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 811 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME ROSE C. Mc KENNA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 14, 1872

8. AGE: Years 75 | Months 10 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Hartford Co. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Thomas Mc Kenna
13. Birthplace Ireland

MOTHER
14. Maiden Name Anne Mc Gee
15. Birthplace Ireland

16 (a) Informant Miss Mary A. McKenna
(b) Address 811 W. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. H. Mears and Son
(b) Address 805 N Calvert St.

FEB 20 1948 (Date rec'd by registrar)

(b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/18 1948, at 5 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/6 1947 to 2/18 1948 and that I last saw h[illegible] alive on 2/18 1948

Immediate cause of death: Arteriosclerotic Cardio Vascular Disease — Duration

Due to

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elmore Coughlan M. D.
Address 400 N. Payson St. Date signed 2/18/48

X

G60369

BALTIMORE CITY HEALTH DEPARTMENT

BC: 48-03453 CERTIFICATE OF DEATH 1604

Registered No. G60369

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner and Dukeland Sts.
(c) Hospital or institution: Provt Balt. Gen. Hospital 25-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 10 min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt. 29.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 530 Random Rd.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Boy Hoyme

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2-14-48

8. AGE: Years | Months | Days | If less than one day hr. 10 min.

9. Birthplace Balt. Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

MOTHER
12. Name Gladys Hoyme
13. Birthplace Wanburn, Minn.
14. Maiden Name Gladys Stansbury
15. Birthplace Balt. Md.

FATHER
16 (a) Informant Gladys Hoyme
(b) Address 530 Random Rd.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location Johns Hopkins Medical School FEB 19 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-14- 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-14 1948 to 2-14 1948 and that I last saw h[illegible] alive on 2-14 1948

Immediate cause of death Subarachnoid hemorrhage — Duration

Due to Breech Presentation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Subarachnoid hem

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. J. Treptow M. D.

Address W Bg H Date signed 2-16

VS 150

G60370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G60370

To correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. TYPEWRITER PREFERRED, WITH UNREADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Ba.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 16 E. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Houston Patterson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Allie Fortune (Ella M)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 11, 1886

8. AGE: Years	Months	Days	If less than one day
61	4	3	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation (Elevator Operator)
11. Industry or business

FATHER
12. Name David Patterson
13. Birthplace Virginia

MOTHER
14. Maiden Name Allie Fortune (Ella M)
15. Birthplace Virginia

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 19 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) (Date rec'd by Registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14 1948 at 5 05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 14 1948 to Feb 14 1948 and that I last saw him alive on Feb 14 1948.

Immediate cause of death Uremia

Due to Chronic glomerular nephritis with

Due to Acute Anuria

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank A. Farano M.D.
Address Mercy Hosp Date signed 2/18/48

VS 150

669371

AB-69425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

Registered No. 669371

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 2-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 259 S. Ann St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George P. Roberts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Separated

6 (b) Name of husband or wife Clara Thompson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept- 30-1856

8. AGE: Years	Months	Days	If less than one day
91	4	12	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Old Age Pension
11. Industry or business

MOTHER / FATHER
12. Name Benjamin Roberts
13. Birthplace Maryland
14. Maiden Name Jane Ann Gudard
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Loc Johns Hopkins Medical School FEB 19 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 20 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12- 1948, at 11.55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17- 1941 to 2-12 1948, and that I last saw h. im alive on 2-12- 1948.

Immediate cause of death	Duration
Cardiac failure.	
Due to Arteriosclerotic Cardiovascular Disease	
Due to	
Other Conditions Carcinoma of Lar.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. J. Bamford M. D.
Address Balt. City Hosp. Date signed 2-19-48

VS 150

G60372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G60372

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1500 JOHN St.
(c) Hospital or institution: 14-1
(d) Length of stay in ~~hospital or inst. (yrs., mos., or days)~~ ABOVE ADDRESS 10 YRS.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1500 JOHN St.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME LEONARD GRANT PASSANO

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced WIDOWED

6 (b) Name of husband or wife BELLE —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR 7, 1872

8. AGE: Years 75 | Months 10 | Days 11 | If less than one day ... hr. ... min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business —

FATHER
12. Name WM. R. PASSANO
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name MARION GRANT
15. Birthplace N. Y.

16 (a) Informant MRS. ANNE K. BAILEY
(b) Address 93 MUNRO BLVD. VALLEY STREAM L. I.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/20/48 (month) (day) (year)
(c) Cemetery or crematory WOODLAWN
Location BALTO. CO., MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTIMORE, MD.

19 (a) FEB 20 1948 (b) [illegible]
Filed by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/18/48 ~~19~~, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/16 19 48 to 2/18 19 48
and that I last saw h[illegible] alive on 2/17 19 48

Immediate cause of death Outlet — Duration
Obstruction Carcinoma - Stomach
disease
Due to —
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Krumbhaar M. D.
Address 142 E. Lanvale St. Date signed 2/19/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G60373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G60373 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3809 JUNIPER RD.
(c) Hospital or institution: 12-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3809 JUNIPER RD. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME KATHRYN E KIRK

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: WIDOW
6 (b) Name of husband or wife: WILLIAM WATERS
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): NOV. 10, 1879

8. AGE: Years 68 | Months 3 | Days 9 | If less than one day — hr. — min.

9. Birthplace: BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation: HOUSEWIFE
11. Industry or business: —

FATHER
12. Name: WM. PITT KIMBALL
13. Birthplace: WATERTOWN, N.Y.

MOTHER
14. Maiden Name: MARY OLIVIA DAUGHADAY
15. Birthplace: BALTIMORE, MD.

16 (a) Informant: MRS. ROBERT HECHT
(b) Address: 3809 JUNIPER RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/21/48 (month) (day) (year)
(c) Cemetery or crematory: LOUDON PK.
Location: BALTIMORE, MD.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: BALTIMORE, MD.

19 FEB 20 1948 (b) Huntington Williams, M.D. Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/19/48 —, at 12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 17 Feb 1948, to 19 Feb 1948, and that I last saw h[illegible] alive on 17 Feb 1948.

	Duration
Immediate cause of death: Cholemia	6 hours
Due to: Metastatic cancer Liver	6 mos +
Due to: Carcinoma Head of Pancreas	6 mos +
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature [signature] M. D.
Address 2020 N Charles St. Date signed 2/20/48

X

660374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 660374

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 EUTAW PLACE
(c) Hospital or institution: Yakima Convalescent Home ABOVE ADDRESS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 WKS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1120 W. CROSS ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) —
If yes, name country

3 (a) FULL NAME: J. GEORGE EPPLER

3 (b) If veteran, name war: —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	WIDOWED

6 (b) Name of husband or wife CATHERINE S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 26, 1859

8. AGE: Years	Months	Days	If less than one day
88	2	23	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business —

FATHER
12. Name JACOB EPPLER
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace —

16 (a) Informant MR. GEO. M. EPPLER
(b) Address 1120 W. CROSS ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/21/48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PK.
Location BALTIMORE, MD.

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address BALTIMORE, MD.

19 (a) FEB 20 1948 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/19/48 (month) (day) (year), at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 18 1948 to Feb. 18 1948, and that I last saw h[illegible] alive on Feb 18 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Adv. Arteriosclerosis	
Due to	
Other Conditions Convales. fract. left hip	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 21/2
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Jan 20 M
(c) Where did injury occur? (City or town) Balto (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? [illegible] While at work? No (Specify type of place)
(e) Means of injury Fell on floor

23. Signature [illegible] M. D.
Address 1700 Eutaw Pl. Date signed 2-19-48

Howard J. Sheeder M.D.

VS 159

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G60375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G60375 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15.6
(c) Hospital or institution: West Balto. Genrl Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 DAY
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2930 BAKER ST. (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country —

3 (a) **FULL NAME** ANTHONY HUGO DEL NEGRO

3 (b) If veteran, name war: No

3 (c) Social Security Account No. YES

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: KATHERINE E.

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1912

8. AGE: Years 35 | Months 4 | Days 27 | If less than one day: ____ hr. ____ min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation TAX CONSULTANT

11. Industry or business —

FATHER
12. Name PHILIP DEL NEGRO
13. Birthplace ITALY

MOTHER
14. Maiden Name IDA PARMIGIANI
15. Birthplace ITALY

16 (a) Informant MRS. KATHERINE E. DEL NEGRO
(b) Address 2930 BAKER ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/23/48 (month) (day) (year)
(c) Cemetery or crematory LORRAINE
Location BALTO. CO. MD.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address BALTO., MD.

19 (a) FEB 20 1948 (Date rec'd by registrar) (b) Registrar's No. 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19-48 19__, at 12:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-18 1948 to 2-19 1948, and that I last saw him alive on 2-19- 1948.

Immediate cause of death Cardiac failure — Duration: ____

Due to Coronary occlusion — Duration: ____

Due to Myocardial infarction — Duration: ____

Other Conditions — Duration: ____

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Myocardial infarction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. W. Birdsong M.D.
Address W. Balto. Md. Date signed 2-19-48

VS 150

660376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1107

Registered No. 660376

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1257 BENTALOU ST
(c) Hospital or institution: 16-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 20 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1257 BENTALOU ST. (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country

3 (a) FULL NAME BERNARD W. BROWN

3 (b) If veteran, name war NONE

3 (c) Social Security Account No. 212-07-4186

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife MARJORIE E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 27, 1890

8. AGE: Years 57 | Months 3 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace A. A. Co., MD. (Town, county, and state)

10. Usual Occupation SALESMAN

11. Industry or business NAT'L BISCUIT CO.

FATHER
12. Name FRANK BROWN
13. Birthplace A. A. Co., MD.

MOTHER
14. Maiden Name SARAH STALLINGS
15. Birthplace A. A. Co., MD.

16 (a) Informant WIFE
(b) Address SAME.

17 (a) BURIAL (Burial, cremation, or removal) **(b) Date thereof** 2/20/48 (month) (day) (year)
(c) Cemetery or crematory LORRAINE CEM.
Location BALTO. CO. MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address 2[illegible] BALTIMORE, MD.

19 (a) FEB 20 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/18/48 19... at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6 1947 to Feb 18 1948 and that I last saw h[illegible] alive on Feb 18 1948

Immediate cause of death Cerebral Hemorrhage — Duration 12 days
Due to Bronchial Pneumonia — 6 days
Due to ... — ...
Other Conditions ...
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: ...
of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at ... M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ (Specify type of place) While at work? ✓
(e) Means of injury ✓

23. Signature [signature] M. D.
Address 421 Poplar Grove Date signed 2/19/48.

VS 150

660377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

660377 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3219 BRIGHTWOOD Ave
(c) Hospital or institution: 28-2
ABOUR HOSPITAL
(d) Length of stay in ~~hospital or inst. (yrs., mos., or days)~~ 36 YRS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3219 BRIGHTWOOD Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country —

3 (a) FULL NAME ALICE R. CASSELL

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: W. HARRY
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): MAR. 22, 1879
8. AGE: Years 68 | Months 10 | Days 27 | If less than one day hr. min.
9. Birthplace BALTIMORE, MD (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business —

FATHER
12. Name JAMES L. RIEHL
13. Birthplace GERMANY

MOTHER
14. Maiden Name KATHERINE EMMERICH
15. Birthplace BALTIMORE, MD.

16 (a) Informant MR. W. HARRY CASSELL
(b) Address 3219 BRIGHTWOOD AVE.
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/21/48 (month) (day) (year)
(c) Cemetery or crematory MT. OLIVET
Location BALTIMORE, MD.
18 (a) Funeral director Wm. J. TICKNER & SONS INC.
(b) Address BALTIMORE, MD.
19 (a) 2-20-1948 (Date received by Registrar) (b) Registrar Huntington for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/19/48 ~~19~~, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1935, to Nov 1947, and that I last saw h[illegible] alive on Nov 1947.

Immediate cause of death	Duration
Acute Cardiac Dilatation	7 hrs
Due to Chr. Cardio Vascular disease	
Due to Hypertension	15 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Michael A. Abrams M. D.
Address 1820 Eutaw Place Date signed Feb 19-48

VS 159

660378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 660378

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.S.A.
(b) Street address 702 Hartford Ave
(c) Hospital or institution 10-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 702 Hartford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bessie E. Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Howard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 51 | Months | Days | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Walter Lee
13. Birthplace Va.

MOTHER
14. Maiden Name Jenny Jackson
15. Birthplace Va

16. (a) Informant Howard Jones
(b) Address 702 Hartford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County Md.

18 (a) Funeral director Joseph B. Cook
(b) Address 1364 N. Central Ave

19 (a) FEB 20 1948 (Date received by Registrar) (b) Huntington Ave Baltimore Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/18 1948, at 6:25 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Schmidt M.D. (Medical Examiner.)
Date signed 2/20/48

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X

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C60379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C60379

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5015 Falls Road

(c) Hospital or institution: none 27-14

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County none

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 5015 Falls Road
(If rural give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. William Sisson Gardner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Mary Maslin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1861

8. AGE: Years	Months	Days	If less than one day
86	4	26	hr. min.

9. Birthplace Athens, Ohio
(Town, county, and state)

10. Usual Occupation physician, retired

11. Industry or business

MOTHER / FATHER

12. Name Rev. Wilson Gardner

13. Birthplace Ohio

14. Maiden Name Emmaline C. Brown

15. Birthplace Va.

16 (a) Informant William N. Gardner

(b) Address 801 N. Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/48 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.

(b) Address 1300 Eutaw Place

19 (a) FEB 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1946 to 18 Feb 1948 and that I last saw him alive on 18 Feb 1948

Immediate cause of death	Duration
Coronary Thrombosis	24 hrs
Due to Arterio-sclerotic	10 yrs
Due to Cardio vascular	
Due to Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature S. Edwin Muller M. D.

Address 2 E. Read St. Date signed

VS 150

Dr Muller X

C60380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30c

Registered No. C60380

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4030 Ridgecroft Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anna Frailer

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Frederick J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24-1897

8. AGE: Years 50 | Months 5 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Vincent Stark
13. Birthplace Prague

MOTHER
14. Maiden Name LENA HRNICKA.
15. Birthplace Prague

16 (a) Informant Frederick J. Frailer
(b) Address 4030 Ridgecroft Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/48 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Harmer Lane

18 (a) Funeral director James H. Valentine
(b) Address 2326 Aiken St.

19 FEB 20 1948 (Date rec'd by registrar) (b) Permit for Williams, M.E. Registrar

VS 139

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19 1948, at 3:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-30 1948, to 2-19 1948, and that I last saw her alive on 2-19 1948.

	Duration
Immediate cause of death: Cerebro Vascular Accident	
Due to: CNS Syphilis Paresis	4 mo.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. L. Jameson M. D.
Address Univ. Hosp. Balto. Md. Date signed 2-19-48

G60381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G60381

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1613- W. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SADIE RINGGOLD GROSS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1887

8. AGE: Years 60 | Months 6 | Days 8 | If less than one day hr. min.

9. Birthplace Calvert Co Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Miss Frances B. Morris
(b) Address 822 N. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 20, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Chas. Sylvester Hall
(b) Address 1691 Druid Hill Ave.

19 FEB 20 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14, 1948, at 11.10 A.M.

21. I certify that I took charge of the remains described above, held an insp.& inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary artery disease.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 2-14-48

X

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

60382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G60382

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 234 - S. Gobbins Ave
(c) Hospital or institution 20-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore — (If outside city or town limits, write RURAL and give town)
(d) Street No. 234 - S. Gobbins Ave (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret - H. Schaper

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Albert - F.

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) 10-31-1915

8. AGE: Years 32 | Months 3 | Days 17 | If less than one day — hr. — min.

9. Birthplace Baltimore - Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Henry Fisher
13. Birthplace Maryland

MOTHER
14. Maiden Name Elsie ?
15. Birthplace Maryland

16 (a) Informant Albert - F. Schaper
(b) Address 234 - S. Gobbins Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 20-feb-48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director E. B. Wippert - Son
(b) Address 130 Eutaw Place - 17

19 (a) FEB 20 1948 (Date filed by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb - 17 - 1948, at 5:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to Feb 17 1948, and that I last saw her alive on Feb 17 1948.

Immediate cause of death Carcinoma Sigmoid — Duration 1 1/4 40

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Jan 1 - 1947

Major findings of operation: Mucus Blastoma Sigmoid

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo A Strauss

Address 1808 N Charles St Date signed 2/19/48

VS 150

Every item of information should be carefully supplied. Names, dates, and addresses, with OMISSIONS AND ERRORS. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

460383 Janny

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 460383

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3121 Rosalie Avenue
(c) Hospital or institution: 27-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3121 Roselia Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ann Schoenig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Valentine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 2, 1877

8. AGE: Years	Months	Days	If less than one day
71	0	16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Michael J. O'Donnell
13. Birthplace Ireland

MOTHER
14. Maiden Name Hannah ?
15. Birthplace Ireland

16 (a) Informant Mr. Valentine Schoenig
(b) Address 3121 Roselia Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-23-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 FEB 20 1948 (Date rec'd by registrar) (b) Lauretta for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18, 1948, at 9:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2, 1948, to Feb. 18, 1948, and that I last saw her alive on Feb. 18, 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 wk
Due to Hypertensive Cardiovascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan Janney M. D.
Address 7101 Harford Rd. Date signed 2/19/48

VS 150

660384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660384

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4236 Belman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph R. Schuster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Anna M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9 1865

8. AGE: Years 82 | Months 9 | Days 16 | If less than one day ..... hr. ..... min.

9. Birthplace Williamsport, Pa. (Town, county, and state)

10. Usual Occupation Retired, Police dept.

11. Industry or business

MOTHER FATHER

12. Name Martin Schuster

13. Birthplace ✓

14. Maiden Name ✓

15. Birthplace ✓

16 (a) Informant Mrs. John Schuster

(b) Address 4236 Belman Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/48 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Brooklyn

18 (a) Funeral director Leonard J. Luck

(b) Address 5303 Harford Road.

19 (a) FEB 20 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19th 1948, at 2:00 P.M.

21. I certify that I took charge of the remains described above, held an Inquest Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X] accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature William J. Helfrich M.D. Medical Examiner.

Date signed 2/17/48

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correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G60385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 131a

Registered No. G60385

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 Cumberland St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 Cumberland St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Andrew Howard

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Delsa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/19/1892

8. AGE: Years	Months	Days	If less than one day
55	6	29	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Delsa Howard
(b) Address 701 Cumberland St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Wes. H. Kelson
(b) Address 1303 Pressalman St

19 (a) FEB 20 1948 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 1948, at 6.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1 1947, to 2/17 1948.
and that I last saw h alive on 2/16 1948.

Immediate cause of death Hypertension
Cardio Renal Disease
Dementia,

Duration
6 Mos.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. S. Jackson
Address Coon Lexington Date signed 2/20/48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

0660386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 0660386

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 624 S. Bond St
(c) Hospital or institution: 31
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 624 S. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stephen Kolb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name ?

13. Birthplace Russia

MOTHER 14. Maiden Name ?

15. Birthplace Russia

16 (a) Informant

(b) Address 624 S. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 21/48 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Baltimore

18 (a) Funeral director Fred W Ozazewski

(b) Address 1930 Eastern Ave

19 (a) FEB 20 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1948 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/30 19 48 to 2/19 19 48, and that I last saw h/ alive on 2/19 19 48.

Immediate cause of death Coronary thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Mitchell F. Kwiatkowski M. D.

Address 616 S. Ellwood Ave Date signed 2/20/48

Mitchell F. Kwiatkowski 2/20/48

660387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. 660387

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 N. Gilmore St
(c) Hospital or institution: 16-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 N. Gilmore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isola Douglas

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	married

6 (b) Name of husband or wife John Douglas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1922

8. AGE: Years	Months	Days	If less than one day
25	7	11	hr. min.

9. Birthplace S. C.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Louis Wilkins
13. Birthplace S.C.

MOTHER
14. Maiden Name Dollie Funderburk
15. Birthplace S.C.

16 (a) Informant Dollie Wilkins
(b) Address 1211 N. Gilmore St

17 (a) Burial (b) Date thereof 2-21-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cheraw S.C.
Location S.C.

18 (a) Funeral director George G. Nelson
(b) Address 1307 Presstman St

19 (a) Feb 20 1948 Huntington Williams, M.D.
(Local Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 1948, at 12 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1948, to — 19—, and that I last saw her alive on Jan 25 1948.

Immediate cause of death Pulmonary Tuberculosis — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert L. Crumlay Jr. M. D.
Address 2024 Madison Ave Date signed 2/20/48

VS 150

X

G60388

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. G60388

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3201 SHANNON DR. 26-3
(c) Hospital or institution: — — — NONE — —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3201 SHANNON DR. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country — — — — —

3 (a) FULL NAME JOHN G. BEIL

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife JOHANNA
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 9-25-1873

8. AGE: Years	Months	Days	If less than one day
74	4	23	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation WHOLESALER
11. Industry or business BAKERY

FATHER
12. Name ANTHONY BEIL
13. Birthplace GERMANY

MOTHER
14. Maiden Name ?
15 Birthplace ?

16 (a) Informant GEORGE BECKMAN
(b) Address 2214 LAKE AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-21-48 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD
18 (a) Funeral director LILLY & ZEILER INC.
(b) Address 403 S. WOLFE ST.
1948 FEB 20 (Date received by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 18, 1948, at 3:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from FEB 16 1948 to FEB 18 1948, and that I last saw h/M alive on FEB 18 1948.

Immediate cause of death	Duration
CORONARY THROMBOSIS	2 DAYS
Due to ARTERIOSCLEROSIS	4 YRS
Due to	
Other Conditions HYPERTENSION	8 YRS

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James J. Kavanaugh M.D. M. D.
Address 3201 N. Calvert St. Date signed 2-20-48

X

VS 150

660389

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

660389
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24 N. Fresson St.
(c) Hospital or institution: — — — none — — 26-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 24 N. Fresson St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country — — — —

3 (a) FULL NAME Marie K. RUGEMER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-27-1898

8. AGE: Years 49 | Months 1 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Thomas Pugh
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Yeager
15. Birthplace Md

16 (a) Informant Thomas Pugh
(b) Address Middle River - Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem.
Location Taylor Ave.

18 (a) Funeral director Tilley & Zeiler Inc.
(b) Address 403 S. Wolfe St.

19 (a) 2-20 (Date rec'd by registrar) (b) Burial Permit

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1948, at 6 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ or accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis
Arteriosclerotic cardiovascular renal disease
Cerebral atrophy
Other Conditions Obesity
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 2/19/48

VS 181

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

660390
AB-117236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

Registered No. 660390

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 25-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12days
(e) Length of stay in Baltimore (yrs., mos., or days) 26yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 Husker Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Banks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Married

6 (b) Name of husband or wife Geneva
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept-15-1896

8. AGE: Years	Months	Days	If less than one day
51	5	3	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Machine Operator
11. Industry or business

FATHER
12. Name George Banks
13. Birthplace ?

MOTHER
14. Maiden Name Alice ?
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 22 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location a. a. County
18 (a) Funeral director Mr Robt. A. Elliott Dyl
(b) Address 1129 N. Carlin St.
19 (a) (Local Registrar) (b) Huntington Williams, M.D. Registrar

FEB 29 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18 1948, at 10.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-6 1948, to 2-18 1948, and that I last saw him alive on 2-18 1948.

	Duration
Immediate cause of death Uremia	weeks
Due to Malignant Hypertension	months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed 2-19-48

X

660391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660391

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Edmondson & Rogers Aves.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Angela J. Hawkins

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race W Lib | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Clifton Hawkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1892

8. AGE: Years 55 | Months 8 | Days 0 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Horan
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Horrigan
15. Birthplace Md.

16 (a) Informant Clifton Hawkins
(b) Address Ellicott City Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-48 (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Balto Md.

18 (a) Funeral director H. C. Higinbotham
(b) Address Ellicott City Md

19 Date received by Registrar FEB 20 1948 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 1948 at 1.10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-6 1948 to 2-19 1948 and that I last saw her alive on 2/19 1948.

Immediate cause of death: Extensive Cerebral Damage
Prolonged Cerebral Anoxia
Due to Spinal Anesthesia Reaction
Chronic Cholecystitis
Due to Chronic Cholelithiasis
Other Conditions

Duration

(Include pregnancy within 3 months of death)
Date of operation 18 Feb 48
Major findings of operation: Chronic Cholecyst. Cholelithiasis
of autopsy As Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W E Zinn M.D.
M. D.
Address St. Agnes Hosp Date signed 19 Feb 48

X

The information should be carefully supplied. Every item of information should be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

660392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 660392

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4207 Anntana Avenue
(c) Hospital or institution: 26-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4207 Anntana Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME TEOFILIA LITERSKA

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Antoni
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24, 1871

8. AGE: Years	Months	Days	If less than one day
76	9	24	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Lawrence Orzechowski
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mr. Peter F. Morris
(b) Address 4207 Anntana Avenue

17 (a) Burial (b) Date thereof 2/23/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Road

18 (a) Funeral director M. F. Sadowski & Sons
(b) Address 1808 Eastern Avenue

19 (a) Date received by (Registrar) Huntington for Williams M.D.
FEB 20 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18 1948, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1948 to Feb. 18 1948, and that I last saw her alive on Feb. 17 1948.

Immediate cause of death	Duration
Bronchopneumonia	2 days
Due to Chr. Nephritis & Chr. Hypertension & Arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. L. Bentzel M. D.
Address 200 E. Pratt St. Date signed 2/20/48

C60393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. 1360393

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1429 W. Mulberry St
(c) Hospital or institution: 19-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1429 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Isabelle Winston.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	married

6 (b) Name of husband or wife Ellwood Winston
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 16, 1920

8. AGE: Years	Months	Days	If less than one day
28	1	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Brown.
13. Birthplace Jacksonville, Florida

MOTHER
14. Maiden Name Ella Mackey.
15. Birthplace Baltimore, Md.

16 (a) Informant Ellwood Winston
(b) Address 1429 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 20 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 822 N. Schroeder St.

19 FEB 20 1948 (Entered by Registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17 1948, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 17 1948 to Feb 17 1948 and that I last saw h[illegible] alive on Feb 17 1948.

Immediate cause of death Pulmonary Tuberculosis — Duration 6 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. W. Rectter

Address [illegible] Date signed Feb 20 48

VS 190

X

G60394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G60394

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2123 W. Lexington St.
(c) Hospital or institution: 20-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2123 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma A. Tiepermann

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Max Tiepermann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1872

8. AGE: Years	Months	Days	If less than one day
75	5	18	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name John P. Frank
13. Birthplace Germany

MOTHER
14. Maiden Name Doroethea Scheck
15 Birthplace Germany

16 (a) Informant Emma Tiepermann
(b) Address 2123 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Frederick A. Cole
(b) Address 1200 W. Lombard St.

19 (a) [illegible] Registrar Huntington Williams, M.D. Registrar

FEB 20 1948

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17th 1948, at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 13 1948 to Feb 17 1948, and that I last saw her alive on Feb 17 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Coronary Thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Scagnetti M. D.
Address 1729 W. Lombard St. Date signed 2/18/48

X

G60395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G60395 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Pk. Drive & 31st St.

(c) Hospital or institution: US Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days): 419 days

(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County: Baltimore

(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No.: 83 Murdock Rd. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country:

3 (a) FULL NAME: Vincent Russo

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Elizabeth Tyler Russo

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 6, 1894

8. AGE: Years	Months	Days	If less than one day
54	1	13	hr. min.

9. Birthplace: ? Italy (Town, county, and state)

10. Usual Occupation: Salesman

11. Industry or business:

FATHER — 12. Name: August Russo

FATHER — 13. Birthplace: Italy

MOTHER — 14. Maiden Name: Bernadette Lafotte

MOTHER — 15 Birthplace: Italy

16 (a) Informant: Records

(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/48 (month) (day) (year)

(c) Cemetery or crematory: Holy Redeemer

Location: Balto. City.

18 (a) Funeral director: C. Verna Lemmon

(b) Address: 4611 Pk. Hgts

19 (a) FEB 20 1948 (Date rec'd by registrar) Huntington Williams Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 19 1948, at 3:25P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 27 1946 to Feb. 19 1948, and that I last saw him alive on Feb. 19 1948

Immediate cause of death	Duration
Carcinoma of prostate with metastases, multiple, ~~Dxxx~~ and ~~xxxxxx~~ metastasis to liver	5 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation: 9/13/46 - 1/23/48

Major findings of operation: 12 individual procedures

of autopsy: As above

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature: Robert M Foote

Robert M. Foote, M. D.

Address: Marine Hospital Date signed: 2/19/48

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G60396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 D

Registered No. G60396

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 21-1
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~1500~~ 1003 ~~Ridgley St.~~ Russell ST (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER C. SCHLABECKER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 9, 1888

8. AGE: Years	Months	Days	If less than one day
59	6	10	hr. min.

9. Birthplace BALTO. MD
(Town, county, and state)
10. Usual Occupation LABORER
11. Industry or business

FATHER
12. Name JOHN SCHLABECKER
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARGARET MACHER
15. Birthplace GERMANY

16 (a) Informant MRS CILLIAN CASPARE
(b) Address 1003 RUSSELL ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Feb 21, 1948 (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL
Location Annapolis Rd - Brooklyn

18 (a) Funeral director Harry A Wetzler
(b) Address 1340 Edmondson Ave

19 (a) FEB 20 1948 (Date rec'd by registrar) Courtenay Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19, 1948, at 7.30 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Syphilitic aortitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 2-19-48

VS 151

Please write in ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

660397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. 660397

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. ATHOL AVE
(c) Hospital or institution: GERMAN AGED HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S ATHOL AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CLARA VIRGINIA MACKECHNEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 12, 1864

8. AGE: Years	Months	Days	If less than one day
83	4	6	hr. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation RETIRED SCHOOL-TEACHER

11. Industry or business

FATHER
12. Name JOHN FRANCIS MACKECHNEY
13. Birthplace NEW JERSEY

MOTHER
14. Maiden Name ANN REBECCA NEWPORT
15. Birthplace MD

16 (a) Informant J. GEORGE WALZ - SECTY
(b) Address 22 S. ATHOL AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB 21 1948 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location 3801 FREDERICK AVE

18 (a) Funeral director Harry A. Wilson
(b) Address 4101 Edmondson Ave

19 (a) FEB 20 1948 (Date received by Registrar) (b) Huntington Woods, Md.

MEDICAL CERTIFICATION 5.20 P.

20. DATE OF DEATH FEB. 18 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10/48, to Feb. 18/48, and that I last saw her alive on Feb. 17/48.

Immediate cause of death — Duration

Possible Uterine Cancer — Unknown.

Due to

Due to

Other Conditions
Multiple Sclerosis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Emily Wardo Saunders M. D.
Address 900 Hanover Date signed Feb 19/48

VS 150

G60398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

Registered No. G60398

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 438 W Hamilton St

(c) Hospital or institution:

22-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 438 W Hamilton St (If rural give location)

(e) Citizen of foreign country? (Yes or No) ✓

If yes, name country

3 (a) FULL NAME Harry Watts

3 (b) If veteran, name war ✓

3 (c) Social Security Account No.

4. Sex M

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 53 | Months | Days | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Kirk & Burlington Lumber Co

MOTHER / FATHER

12. Name James Watts

13. Birthplace Md

14. Maiden Name Annie Watts

15. Birthplace Baltimore Md

16 (a) Informant Adyeline Watts

(b) Address 1034 Leadenhall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Balto Md

18 (a) Funeral director Isaiah L Brown Sons

(b) Address 1686 Montgomery St

19 (a) FEB 20 1948 (Date received) Huntington Willis (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb (17) 18 1948 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18 1948 to Feb 17 1948

and that I last saw h alive on Feb (17) 18 1948

Immediate cause of death	Duration
Due to Acute Bronchitis	7 days
Due to Influenza	8 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Lingsley Shelton M. D.

Address 68 E. Sharp St. Date signed 2/19/48

VS 150

660399 SYE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

660399 Registered No.

PRINT WITH TYPEWRITER, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 650 Hanover St.
(c) Hospital or institution: 22-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 650 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) Hanover
If yes, name country

3 (a) FULL NAME Charles E. SYE

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business Farmer

FATHER
12. Name Henry Smith
13. Birthplace Md

MOTHER
14. Maiden Name Mary Harris
15. Birthplace Md

16 (a) Informant Violet Sye
(b) Address 526 W Conway St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore Md

18 (a) Funeral director Isaiah L Brown Son
(b) Address 1084 W Montgomery St

19 (a) FEB 20 1948 (Date received by registrar) (b) for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1948 at 2 P.M.

21. I certify that I took charge of the remains described above, held an Inspection + Inq Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George E. Merrill M.D. Medical Examiner.
Date signed 2/17/48

X

660400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 660400

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.St
(b) Street address 128 S. High St
(c) Hospital or institution: 3-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 128 S. High St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Macey (Marcey)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 56 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Delaware
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name George Macey
13. Birthplace Del

MOTHER 14. Maiden Name Eliza ?
15. Birthplace Del

16 (a) Informant Gertrude Richardson
(b) Address 128 S. High St

17 (a) Burial (b) Date thereof 2-21-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Marley Cemetery
Location A. A. Co., Md.

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) FEB 20 1948 Huntington Williams, M.D.
(Registered by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/18 1948, at 4:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of left Breast

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Gilbride M.D.
Medical Examiner.
Date signed 2/19/48

VS 191

The information requested on this certificate, while DISTRESSING INDEED, is necessary and important. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

660401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. 660401

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St
(c) Hospital or institution: Good Samaritan Home 1-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2931 O'Donnell St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Chas. WM. Whitemore

3 (b) If veteran, name war --

3 (c) Social Security Account No. 212-18-0482

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Margaret M. Whitemore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1914

8. AGE: Years 33 | Months 3 | Days 5 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER
12. Name Chas. E. Whitemore
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Annie Ehm
15. Birthplace Balto. Md.

16 (a) Informant Margaret M. Whitemore
(b) Address 2931 O'Donnell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 21/48 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto. Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 FEB 20 1948 (Date received by Registrar) Hunting for Williams MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18/48 19..., at M

21. I certify that death occurred on the date above stated; that I attended deceased from 17 Feb. 1948, to 19..., and that I last saw him alive on 17 Feb 1948.

Immediate cause of death Bronchopneumonia Pa.

Due to

Due to

Other Conditions Marasmus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: Unknown / 2 mths.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Tommasello M. D.

Address 9 co W. Lombard Date signed 20 Feb.

V S 150

X 1948

G60402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G60402 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 54
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 407 N. Spring St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John R Nutt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	blond	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-75

8. AGE: Years	Months	Days	If less than one day
72	5		hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Robert Nutt
13. Birthplace Va.

MOTHER
14. Maiden Name Unk
15. Birthplace Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 21, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn, Md.

18 (a) Funeral director Clarence L. Wilson
(b) Address 1010 Fayette ave Huntington Williams, Md.

FEB (a) 23 1948 (registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb- 15 1948 at 6:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb- 11 1948 to Feb- 15 1948 and that I last saw him alive on Feb- 15 1948

Immediate cause of death Hypostatic Pneumonia — Duration

Due to Arteriosclerotic heart disease

Due to Fract. left hip.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 5/1
(a) Accident, suicide, or homicide Fall
(b) Date of occurrence 11 Feb 48 at M
(c) Where did injury occur? Balto (City or town) Balto (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? At home (Specify type of place) While at work?
(e) Means of injury Fall down stairs

23. Signature R. S. Mosiman
Address Johns Hopkins Date signed 18 Feb M. D.

VS 150 To be approved by Dr. Maddox Wm. G. Helsrich M.E. per Med. Examiner J. Maddox, M.D.

G60403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122B

G60403

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days

(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Pa. (b) County

(c) City or town Shrewsbury

(If outside city or town limits, write RURAL and give town)

(d) Street No. Main Street

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME SARAH GRISSELE FIFE

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5 1853

8. AGE: Years	Months	Days	If less than one day
94	7	15	hr. min.

9. Birthplace Shrewsbury Pa

(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER

12. Name Noah Fife

13. Birthplace Pa.

MOTHER

14. Maiden Name Anna Davis

15. Birthplace Pa.

16 (a) Informant Mrs. W.A. MacCuffin

(b) Address 2730 Fennieldane Rd

17 (a) Removal (b) Date thereof 2/21/48

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lutheran Cemetery

Location Shrewsbury, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (b)

(Date received by registrar) Registrar

FEB 20 1948

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 1948 at 1:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-14 1948 to 2-20 1948 and that I last saw h~~e~~r alive on 2-19 1948.

Immediate cause of death Intestinal obstruction — Duration 11 days

Due to unknown

Due to

Other Conditions Phlebitis left leg.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Richard H. Martin M. D.

Address Maryland Gen. Hosp. Date signed 2-20-48

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G60404

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G60404
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 136 E Randall St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 136 E Randall St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cordelia M. Davern 18

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Lawrence A Davern Sr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec 25 - 1876

8. AGE: Years 71 Months 1 Days 24 If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER 12. Name Dennis Wright

13. Birthplace Va

MOTHER 14. Maiden Name Octavia Roche

15 Birthplace Baltimore Md

16 (a) Informant Mrs Joseph Rappenger

(b) Address 136 E Randall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/48 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Old Frederick Road

18 (a) Funeral director Fahey & Lyne

(b) Address 218 Light St.

19 (a) (Date rec'd by registrar) FEB 21 1948 (b) Huntington Williams M.D. Registrar

Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17, 1948, at 1.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1948 to Feb 17 1948, and that I last saw her alive on Feb 17 1948.

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	
Due to Coronal Thrombosis	6 days
Due to Cardiac Dilatation	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Vincent M. Messina M.D.

Address 1403 8 Charles St Date signed 2/18/48

X

If any item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C60405

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a

Registered No. C60405

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 400 WOODFORD RD.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 400 WOODFORD RD. (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country —

3 (a) FULL NAME ELIZABETH COONAN KENNARD (BESSIE)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or ~~wife~~ EDWARD M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 1, 1892

8. AGE: Years 55 | Months 11 | Days 17 | If less than one day hr. min.

9. Birthplace WESTMINSTER, MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER
12. Name JOSEPH COONAN
13. Birthplace MD.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace "

16 (a) Informant MR. EDWARD M. KENNARD
(b) Address 400 WOODFORD RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/21/48 (month) (day) (year)

(c) Cemetery or crematory LOUDON PK.
Location BALTIMORE, MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTIMORE, MD.

19 (a) FEB 21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/18/48 19 at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-17- 1947, to 2-18 1948, and that I last saw her alive on 2-18 1948.

	Duration
Immediate cause of death: Hypertensive - Cardio-Renal Disease	2 YRS-
Due to: —	
Due to:	
Other Conditions: Thyroidectomy. Tracheotomy	1935 1936

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature F. Carozza.
Address 3217 York Rd. Date signed 2/20/48

VS 159

G60406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G60406

The information above must be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1629 KINGSWAY RD.
(c) Hospital or institution:
ABOVE ADDRESS
(d) Length of stay in ~~hospital or inst. (yrs., mos., or days)~~ 5 YRS.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 KINGSWAY RD. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATHERINE V. GORMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
NONE	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOW

6 (b) Name of husband or wife JOHN L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUN 27, 1872

8. AGE: Years	Months	Days	If less than one day
75	7	21	hr. min.

9. Birthplace BALTO., MD. (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name PATRICK DOWNEY
13. Birthplace IRELAND

MOTHER
14. Maiden Name MARGARET KEILEY
15. Birthplace IRELAND

16 (a) Informant MRS. WEBSTERA LIPPER
(b) Address 1629 KINGSWAY RD.
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/21/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ NEW CATHEDRAL
Location BALTIMORE
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTIMORE MD
19 (Date rec'd by registrar) FEB 21 1948 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/18/48 19 , at 3:15 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 to Feb 1948 and that I last saw her alive on Feb 17 1948

Immediate cause of death	Duration
Intestinal Obstruction	3 weeks
Due to Cancer of descending colon	2 y.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Gregory J. Kane M. D.
Address 2607 Fenton Date signed 2/20/48

VS 150

X

60402 A 60562

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 157E

Registered No. 60407

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ky. (b) County
(c) City or town Ashland (If outside city or town limits, write RURAL and give town)
(d) Street No. 1717 Madison Av (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sandra Kay Clemons

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-3-47

8. AGE: Years | Months: 4 | Days: 16 | If less than one day: hr. min.

9. Birthplace Ky. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John R. Clemons
13. Birthplace Ky.

MOTHER
14. Maiden Name Mary Green
15. Birthplace Ky.

16 (a) Informant Parents
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/20/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Ashland
Location Boyd Co. Kentucky

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) FEB 21 1948 (Date rec'd by registrar) (b) Huntington, W. Va. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 1948 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7 1948 to Feb. 19 1948 and that I last saw h[illegible] alive on Feb. 19 1948

Immediate cause of death — Duration: Life
Cong. Heart Disease, Cyanotic
Due to
Due to
Other Conditions Hydrocephalus, Spina Bifida Occ.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. W. Lipscomb M.D.
Address Johns Hopkins Hosp Date signed 2/20/48

X

G60408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G60408

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 31 days
(e) Length of stay in Baltimore (yrs., mos., or days): 31 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Baltimore
(c) City or town: Pikesville (If outside city or town limits, write RURAL and give town)
(d) Street No.: Villanova (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Joseph Michael Joyce

3 (b) If veteran, name war: WWI

3 (c) Social Security Account No.: 303-05-6919

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Div.

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 21, 1886

8. AGE: Years: 61 | Months: 1 | Days: 27 | If less than one day: hr. min.

9. Birthplace: Cincinnati, Ohio (Town, county, and state)

10. Usual Occupation: none

11. Industry or business:

FATHER
12. Name: Thomas C. Joyce
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Katherine Debes
15. Birthplace: Cincinnati, Ohio

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Frederick Rd., Balto Md

18 (a) Funeral director: Frank H. Mauro
(b) Address: Pikesville, Md.

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 17 1948, at 9:55PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 17 1948 to Feb. 17 1948 and that I last saw him alive on Feb. 17 1948

	Duration
Immediate cause of death: Coronary sclerosis with subtotal occlusion	Unknown
Due to: Renal calculi bilateral, large, with hydronephrosis and	Unknown
Due to: uremia	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M.D.
Address: Clinical Director Date signed: 2/20/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

660409

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 660409

660409

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3704 Mt. Pleasant Avenue
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3704 Mt. Pleasant Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Charles E. Rankin

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 214 20 6286

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Maude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1870

8. AGE: Years 77 | Months 6 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual Occupation: Ship Yard Worker

11. Industry or business: Fairfield

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Unknown

16 (a) Informant: George Mugrage
(b) Address: 3704 Mt. Pleasant Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 23-48 (month) (day) (year)
(c) Cemetery or crematory: Glen Haven Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: Wm. Cook Inc.
(b) Address: 1217 St. Paul Street

19 (a) (b) Huntington Williams, M.D.

Filed FEB 23 1948 (by registrar)

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Feb. 19 -48 19..., at 4:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1948 to Feb 19 1948, and that I last saw him alive on Feb 19 1948

Immediate cause of death: Myocardosis — Duration 2

Due to: Arteriosclerotic heart disease

Due to: Asteriosclerosis

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: John J Gould M. D.

Address 141 East Ave Date signed 2-20-48

VS 150

X

660410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55B

Registered No. 660410

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 56 days
(e) Length of stay in Baltimore (yrs., mos., or days) 73 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town TOWSON (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 GREENBRIAR Rd. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME MRS BERTHA O. KENDALL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife RUBEN FOSTER KENDALL (D) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 30, 1875

8. AGE: Years	Months	Days	If less than one day
73	0	20	hr. min.

9. Birthplace BALTIMORE, MARYLAND (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name HANSON H. KEYS (D)
13. Birthplace MARYLAND

MOTHER
14. Maiden Name ANNE KEYS (D)
15. Birthplace MARYLAND (D)

16 (a) Informant WILLIAM O. KENDALL
(b) Address NORTHWIND Rd - TOWSON, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 FEB 21 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-20-48 19 , at 12:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-26-47 to 2-20-48, and that I last saw her alive on 2-20-48 19

Immediate cause of death	Duration
SARCOMA OF SKULL	5 MONTHS
Due to PAGET'S DISEASE	UNKNOWN
Due to	
Other Conditions NONE (Include pregnancy within 3 months of death)	
Date of operation NONE	
Major findings of operation:	
of autopsy: NONE	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter L. Hatchard M.D.
Address Union Memorial Hosp. Baltimore 18, Md. Date signed 2-20-48

VS 150

X

G60411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G60411

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) Always

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 N. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Mary Dorothy Hellwig
3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex female
5. Color or race white
6 (a) Single, married, widowed, or divorced. single
6 (b) Name of husband or wife none
6 (c) If alien, give age 9 years
7. Birth date of deceased (mo., day, yr.) June 10 1877
8. AGE: Years 70 Months 8 Days 10 If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Mr. Justus H. Hellwig
13. Birthplace Germany

MOTHER
14. Maiden Name Mrs. Sophie Ebeler
15. Birthplace Germany

16 (a) Informant Mrs. D. J. Hellwig
(b) Address 446 N. Paca St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.
18 (a) Funeral director Wilson Cook Inc.
(b) Address 1519 N. Paca St.
19 (a) FEB 21 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/19/48 19 , at 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/16/48 19 to 2/19/48, and that I last saw h[illegible] alive on 2/19/48.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Arterio Sclerosis, Manual	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Cerebral Hemorrhage
of autopsy: arterio-Sclerosis, Manual

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Hartman
Address Church Home & Hosp. Date signed 2/19/48 M D

VS 153

X

The Registrar will not register this certificate unless it is complete in every detail. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G60412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. G60412

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1328 N. Carey St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 1328 N. Carey St (If outside city or town limits, write RURAL and give town)
(d) Street No. Balto (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dr. Luther E. McNeil
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Rose
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 6/19/1884

8. AGE: Years	Months	Days	If less than one day
63	8	-	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Pharmacist
11. Industry or business

FATHER
12. Name Henry McNeill
13. Birthplace N. C.

MOTHER
14. Maiden Name Lucy —
15. Birthplace N. C.

16 (a) Informant Rose McNeill
(b) Address 1328 N. Carey St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.
18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pleasman St
19 FEB 21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1948, at 4:45 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 2-15-1948 to 2-19-1948 and that I last saw h— alive on 2-15-1948.

Immediate cause of death
Cerebral Embolism
Due to Arterio Sclerosis
Due to Hypertension
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Wm B Butler M. D.
Address 2033 Eutaw Pl Date signed 2/21/48

060413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 138

Registered No. 060413

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto. City
(b) Street address Druid Hill Center Clinic
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 812 Lowe Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RUTH BREWINGTON THOMAS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Albert Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1922

8. AGE: Years 25 | Months 10 | Days | If less than one day hr. min.

9. Birthplace n. c. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Ramon Brewington
13. Birthplace n. c

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Grace Hardy
(b) Address 115 S. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-48 (month) (day) (year)
(c) Cemetery or crematory Greenville n. c.
Location n. c.

18 (a) Funeral director George H. Nelson
(b) Address 1303 Preestman St

19 (a) FEB 21 1948 (Date rec'd by registrar) (b) Beatrice Lee Hollingsworth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18, 1948, at 8.40 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil Rogan M.D.
Medical Examiner.
Date signed 2-19-48

VS 191

X

G60414

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G60414

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 830 Hellington Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 830 Hellington Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Alice L. Alban

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife George Howard Alban
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25 1875

8. AGE: Years 72 | Months 11 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Theophilus Little
13. Birthplace Virginia

MOTHER
14. Maiden Name Sabrah D. Lockman
15. Birthplace Maryland

16 (a) Informant Mrs. Edith Banks
(b) Address 830 Hellington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 23. 1948 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 FEB 21 1948 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20. 1948, at 10 45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to Feb 20 1948 and that I last saw her alive on Feb 19 1948.

Immediate cause of death	Duration
Pulmonary Embolism or infarction	1 hour
Due to Phlebitis of leg arteriosclerosis &	10 days
Due to Hypertensive Cardiovascular	15 years
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Leonard Wallenstein M. D.
Address 878 W 36th St Date signed Feb 20/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

660415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. 660415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2408 Francis st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2408 Francis st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Edna Ann Davis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	Colored	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 20 -- 1869

8. AGE: Years	Months	Days	If less than one day
59	7	29	hr. min.

9. Birthplace Prince Edward Va
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Henry Jackson
13. Birthplace Va

MOTHER
14. Maiden Name Margaret Johnson
15. Birthplace Va

16 (a) Informant Elsie Bolden
(b) Address 2430 Francis St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-48 (month) (day) (year)
(c) Cemetery or crematory
Location Mt Calvary

18 (a) Funeral director William H Jackson
(b) Address 916 Penna Ave

19 FEB 21 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1948, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 1 1947, to Feb 19 1948, and that I last saw h-r alive on Feb 19 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 hour
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ann O Johnson M. D.
Address 2329 Guilford Ave Date signed Feb 19 1948

X

660416

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 877

660416
Registered No.

PRINT NAME, FIRST, MIDDLE, LAST IN HANDWRITING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1119 N. Patterson Pk
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 N. Patterson Pk Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. [illegible] Ringrose
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow.

6 (b) Name of husband or wife Charles W. Ringrose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25. 1869

8. AGE: Years	Months	Days	If less than one day
79		24	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name James Hooper
13. Birthplace Balto Md.
14. Maiden Name Mary R. Snyder
15. Birthplace Balto Md.

16 (a) Informant Mrs Edith Conway
(b) Address 1119 N. Patterson Pk Ave

17 (a) Burial (b) Date thereof 2-23-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto Cem.
Location North Ave.

18 (a) Funeral director Philip E. Miller Sons
(b) Address 2435 E. Oliver St

19 (a) FEB 21 1948 (b) Lucretia Williams M.D.
(To be filled in by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19 1948 at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10, 1948 to Feb. 19, 1948, and that I last saw h alive on 19 .

Immediate cause of death	Duration
Septicemia	6 days
Due to Erysipelas of Face	9 "
Due to Streptococcus infection in mouth and throat.	9 "
Other Conditions Arteriosclerosis	3 yrs.
Cerebral Sclerosis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert G. Dengrovold
Address 1616 E. North Av. Date signed 2-20-48

VS 150

X

660417 RUHE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

660417 Registered No.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 803 N. Ellwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 803 N. Ellwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William L. Ruhe
3 (b) If veteran, name war
3 (c) Social Security Account No. 215-10-2721
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Viola H. Ruhe
6 (c) If alive, give age 48 years
7. Birth date of deceased (mo., day, yr.) Jan. 15-1898
8. AGE: Years 51 Months 50 Days 1 If less than one day hr. min. 4
9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Ind Civil
11. Industry or business Glen L. Martin Co

MOTHER / FATHER
12. Name Wm. L. Ruhe Jr.
13. Birthplace Balto. Md.
14. Maiden Name Henrietta Pistner
15. Birthplace Balto Md

16 (a) Informant Viola H. Ruhe
(b) Address 803 N. Ellwood Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-23-48 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location O'Donnell St
18 (a) Funeral director John E. Mullen Jr
(b) Address 345 E. O'Donnell St
19 (a) FEB 21 1948 (Date rec'd by registrar) (b) Livingston Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19-1948 at M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to 2-19 1948, and that I last saw h[illegible] alive on Feb 19 1948.

Immediate cause of death Acute Urinary Suppression — Duration
Due to Chronic Nephritis
Due to Hypertension, Arteriosclerosis
Other Conditions Uremia, Enlarged Heart, Anemia, Convulsions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter A Patterson M. D.
Address 3001 Shannon Drive Date signed 2/20/48

VS 150

660418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 660418

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 St. Carrollton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 405 N Carrollton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca M. Dupree Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	widow

6 (b) Name of husband or wife Thomas Bailey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 19, 1882

8. AGE: Years	Months	Days	If less than one day
65	4	-	hr. min.

9. Birthplace Surry Co, Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name David Woodley
13. Birthplace Surry Co Va

MOTHER
14. Maiden Name Mary Vaskin
15. Birthplace Surry Co Va

16 (a) Informant Thomas Bailey
(b) Address 1001 W. Lafayette Ave

17 (a) Burial (b) Date thereof Feb 22, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) FEB 21 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 1948, at 4:11 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 1948 to Feb 19 1948 and that I last saw h[illegible] alive on Feb 18 1948

Immediate cause of death	Duration
Myocarditis & Uremia	2 days
Due to Carbon. neoplasm	1
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George McDonald M.D.
Address 864 N Carey Date signed 2/21/48

VS 150

660419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. 660419

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5441 Fairlawn AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 d
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5441 Fairlawn Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ruth Malakoff

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Norman H
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17-1918

8. AGE: Years 30 | Months 7 | Days 2 | If less than one day: hr. min.

9. Birthplace Pittsburgh Pa (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Tom Magram
13. Birthplace W. S. A.

MOTHER
14. Maiden Name Bella
15. Birthplace W S A

16 (a) Informant Norman H Malakoff
(b) Address 5441 Fairlawn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-48 (month) (day) (year)
(c) Cemetery or crematory George Washington
Location Washington DC - Memorial

18 (a) Funeral director Edek Lewis Inc
(b) Address 2460 Eutaw Place

19 FEB 21 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 1948, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1948 to Feb 19 1948, and that I last saw h[illegible] alive on Feb 18 1948.

Immediate cause of death: CARCINOMA of RECTUM with METASTASES — Duration: 4 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alvin S. Hertz
Address 5441 Park Heights Date signed 2/19/48

VS 150

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

660420 OC - 91935 BALTIMORE CITY HEALTH DEPARTMENT 1948 Registered No. 660420

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 Orleans St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Theodosia Matthews

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/19[illegible]

8. AGE: Years	Months	Days	If less than one day
	6		hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER FATHER
12. Name James Norman Matthews
13. Birthplace Baltimore Md
14. Maiden Name Mary Wilkins
15. Birthplace Glenville Co. N.C.

16 (a) Informant James N. Matthews
(b) Address 1921 Orleans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 21, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Chas O. Wilson
(b) Address 1000 Bluntly ave

19 (a) FEB 21 1948 (Date rec'd by registrar) (b) Huntington Hollins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20 1948, at 12 30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Aspiration of vomitus

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-19-48 at 7 P M.
(b) Where did injury occur? 1721 Orleans St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Aspiration of vomitus

23. Signature Howard J. Mullis M.D. Medical Examiner.
Date signed 2-21-48

VS 191

X

C60121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

C60121 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1607 Hanover St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 Hanover St
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Allie Wheeler

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 5, 1861

8. AGE: Years 86 | Months 11 | Days 15 | If less than one day: hr. — min.

9. Birthplace Caroline County, Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business —

FATHER
12. Name ? Wheeler
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Maryland

16 (a) Informant Mrs. Frank N. Stores
(b) Address 1607 Hanover St. Balto 30, Md.

17 (a) Burial (b) Date thereof Tues. Feb. 24 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hillcrest Cem.
Location Catonsville, Md.

18 (a) Funeral director C. Howard Evans
(b) Address 4005 S. Charles St., Balto 30, Md.

19 (a) — (b) —
(Date rec'd by registrar) Registrar

FEB 22 1948 Lurington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sun., Feb. 29, 1948, at 9:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1948 to Feb 20 1948 and that I last saw h[illegible] alive on Feb 18 1948.

Immediate cause of death Myocardial degeneration

Due to —

Due to —

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Saturday Schumacher

Address 1337 S. Charles St. Date signed 2/21/48 D.

X

G60122 BALTIMORE CITY HEALTH DEPARTMENT G60122
CERTIFICATE OF DEATH 937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1015 Ashburton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 1015 Ashburton St. (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma A. Shearer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	W.

6 (b) Name of husband or wife Robert E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1854

8. AGE: Years	Months	Days	If less than one day
93	5	19	hr. min.

9. Birthplace N. Y. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Charles Peach
13. Birthplace England.

MOTHER 14. Maiden Name Elizabeth Kelly
15. Birthplace Ireland.

16 (a) Informant Mrs. E. Shearer
(b) Address 1015 Ashburton St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 2/23/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin J. Kyle & Sons
(b) Address 1827 W. North Ave.

19 (a) 1948 (Date rec'd by registrar) (b) Clayton Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-20-48 19, at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-10-47 19 to 2-20-48 19, and that I last saw her alive on 2-19-48 19

Immediate cause of death: Heart disease — Duration: 1 wk
Due to: Arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry F. Lenhart M. D.
Address 2705 Eutaw Pl. Date signed 2-21-48

V S 150

660423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 104

Registered No. 660423

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madeira St & Linden Ave
(c) Hospital or institution:
Maryland Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Rural - Granite
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Howard R. Groomes

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Gertrude
6 (c) If alive, give age / years
7. Birth date of deceased (mo., day, yr.) Sept 12/1888

8. AGE: Years	Months	Days	If less than one day
59	5	9	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Farmer

FATHER
12. Name Thomas J. Groomes
13. Birthplace Montgomery Co Md.

MOTHER
14. Maiden Name Caroline Stouse
15. Birthplace Montgomery Co Md.

16 (a) Informant Gertrude E. Groomes
(b) Address Granite Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 24/1948 (month) (day) (year)
(c) Cemetery or crematory Mt Olive
Location Randallstown Md
18 (a) Funeral director Harry N. Arnascot
(b) Address 4204 Edgewood Ave

19 (a) FEB 22 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-21 1948, at 3:45 A.M

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cardio-Respiratory failure

Due to Bilateral Lobar Pneumonia

Other Conditions Benign Thyroidectomy Right
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature R. B. McFadden M.D. Medical Examiner.
Date signed 2-21-48

VS 151

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G60424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

G60424
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 321 S. Bentalow St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 321 S. Bentalow St.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Elsa Charlotte Imhof

3 (b) If veteran, name war None

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John Henry Imhof

6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) Sept. 2 1877

8. AGE: Years 70 | Months 5 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Lillian M. Fetke
(b) Address 2648 St. Benedict St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-23-48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director George L. Schmelz
(b) Address 2101 Frederick Ave.

19 (a) 2-20-1948 (Date filed by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20, 1948, at 9:16 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9 1947 to Feb 20 1948, and that I last saw her alive on Feb 19 1948.

Immediate cause of death Coronary Thrombosis

Due to Myocardial Weakness

Due to Varicose Ulcer

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

Duration: 3 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Thos. Scott Jr. M. D.
Address 1933 W. Balto. St Date signed 2/20/48

VS 150

660425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56a

660425 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Washington, D.C.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3414 Porter St. NW
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katharine Williams BRITTAIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife John H. Brittain
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/11/03

8. AGE: Years	Months	Days	If less than one day
45	1	10	hr. min.

9. Birthplace Washington, D.C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Charles R. Williams
13. Birthplace Washington, D.C.

MOTHER 14. Maiden Name Jane Spencer
15. Birthplace Michigan

16 (a) Informant Subject Katharine Brittain
(b) Address Washington, D.C.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb. 21, 1948 (month) (day) (year)
(c) Cemetery or crematory
Location Washington D.C.

18 (a) Funeral director Frank Hines
(b) Address Washington D.C.

19 (a) 2 2 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21, 1948, at 5:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 16 1948, to Feb. 21 1948, and that I last saw her alive on Feb. 21 1948

Immediate cause of death Postoperative state following removal of cervix uteri, bilateral salpingo-oophorectomy, excision of endometriosis cyst left ovary. — Duration: 4 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Feb. 17, 1948

Major findings of operation: as above

of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B. Griggs M. D.
Address U. S. Marine Hospital Date signed 2-21-48

VS 150

660126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 21B

Registered No. 660126

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Danville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 641 Holbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wm. Penny Miles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) 2-9-83

8. AGE: Years	Months	Days	If less than one day
65 64	-	12	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name John Miles
13. Birthplace Md.

MOTHER
14. Maiden Name Charlotte White
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb. 21, 1948 (month) (day) (year)
(c) Cemetery or crematory
Location Danville, Va.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) (Date rec'd by registrar) (b) Clarkston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21. 1948, at 3.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 6. 1948. to Feb. 21 1948. and that I last saw him alive on Feb. 21 1948.

Immediate cause of death	Duration
cerebral Hemorrhage	
Due to	
Due to	
Other Conditions Carcinoma of Prostate & metastasis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: WIDESPREAD METASTASIS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wilford A. Councilor Jr M. D.
Address Johns Hopkins Hosp Date signed 2-21-48

VS 190

C60427 BALTIMORE CITY HEALTH DEPARTMENT ✓ C60427
CERTIFICATE OF DEATH 469

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Levindale Home
(a) Baltimore City, Maryland
(b) Street address Belvedere Ave & Greenspring Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2833 Waldorf Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nathan Bolshow

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-3343

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ewa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1892

8. AGE: Years 55 | Months 9 | Days 6 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Clothing Presser

MOTHER | FATHER
12. Name Unknown
13. Birthplace Russia
14. Maiden Name Pearl P
15. Birthplace Russia

16 (a) Informant David Paul
(b) Address 2000 Park ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 22, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Int Carmel
Location German Hill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) 2 29 1948 (Date rec'd by registrar) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Febr. 21st 1948, at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16th 1948 to Febr. 21 1948, and that I last saw him alive on Feb. 20 1948.

Immediate cause of death Cachexia — Duration

Due to Carcinoma pancreatic

Due to

Other Conditions Metastases in abdomen

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jerome J. Blumberg M.D.
Address Levindale Home Date signed Feb 24/48

VS 150

X

G60428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

G60428 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 818 No Washington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis Shapiro

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years: 69 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Morris
13. Birthplace Russia

MOTHER
14. Maiden Name Rose
15. Birthplace Russia

16 (a) Informant Sarah Shapiro
(b) Address 818 N Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2160 Eastern Place

FEB 23 1948 (Date received by registrar) Baltimore, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 Feb 1948 at 1 05 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-15 1947 to 2-21 1948, and that I last saw him alive on 2-24 1948

Immediate cause of death Resp. failure — Duration

Due to Leukemia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bernard S Calun M. D.
Address Sinai Hosp, Balto Md Date signed 21 Feb 48

VS 150

Bernard S. Calun X

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

660429

BALTIMORE CITY HEALTH DEPARTMENT ✓ 660429

CERTIFICATE OF DEATH 131B

Registered No. 660429

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Greenspring ave
(c) Hospital or institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adele Levinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Meyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: 85 years | Months | Days | If less than one day hr. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Abraham
13. Birthplace Russia

MOTHER
14. Maiden Name Gutzel
15. Birthplace Russia

16 (a) Informant Samuel Lowitz
(b) Address 2800 Norfolk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 2100 Eutaw Place

19 (a) 22 1948 Thomas Livingston Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/20 1948, at 7 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 1948 to 2/20 1948 and that I last saw h[illegible] alive on 2/20 1948

Immediate cause of death: Coronary thrombosis — Duration

Due to

Due to

Other Conditions: Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Jerome J. Blumberg
Address Levindale House Date signed 2/20/48 M.D.

VS 150

94a

660430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 83a

660430 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Lombard
(c) Hospital or institution:
Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3704 Cottage Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Rimmelfarb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Jewish	

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Nogel
13. Birthplace Russia

MOTHER
14. Maiden Name Esther
15. Birthplace Russia

16 (a) Informant Mary Rimmelfarb
(b) Address 3704 Cottage Ave

17 (a) Burial (b) Date thereof 2-22-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Rawitz Inc
(b) Address 200 Eastern Place

19 (a) 2-20-1948 (b) Hunting for Williams, Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-20 1948 at 6:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-[illegible] 1948 to 2-20 1948 and that I last saw h[illegible] alive on 2-20 1948

Immediate cause of death Cardiac failure — Duration

Due to pneumonia

Due to Cerebral vascular accident

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard S. Hall M. D.

Address Univ. Hosp. Date signed 2-20-48

660431

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 660431
Registered No. 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2722 Reisterstown Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2722 Reisterstown Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia Oletsky

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 66 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George
13. Birthplace Russia

MOTHER
14. Maiden Name Freda
15 Birthplace Russia

16 (a) Informant Mrs Bessie Singer
(b) Address 2722 Reisterstown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Delair Road

18 (a) Funeral director Jacob Levy Inc
(b) Address 2160 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-21-1948 at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1930 to Feb. 21, 1948, and that I last saw h[illegible] alive on Feb. 17, 1948

Immediate cause of death Myocardial Insufficiency
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sidney D. Levy M. D.
Address 2122 Eutaw Place Date signed 2/21/48

VS 150

Please write plainly, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

660432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

931

660432

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.S.A.
(b) Street address 400 N. Chester St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 400 N. Chester St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hyman Strauss

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-4888

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Esther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Presser

11. Industry or business

MOTHER / FATHER

12. Name Aaron

13. Birthplace Russia

14. Maiden Name Rose

15. Birthplace Russia

16 (a) Informant Esther Strauss

(b) Address 400 N Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-48 (month) (day) (year)

(c) Cemetery or crematory

Location Hebrew Mt Carmel

18 (a) Funeral director Jack Lewis Inc

(b) Address 2600 Eastern Place

19 (a) FEB 22 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/21 1948, at 9:45 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions Emphysema

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature G. M. Saltzman M.D. Medical Examiner.

Date signed 2/21/48

VS 131

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

660433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660433

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MEYER FREIDMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: Sarah Freidman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1876

8. AGE: Years (75) | Months 6 (8) | Days 11 (21) | If less than one day hr. min.

9. Birthplace Russia (Town, County and State)

10. Usual Occupation ~~Meat Cutter~~

11. Industry or business Paper Hanger

FATHER
12. Name David
13. Birthplace Russia

MOTHER
14. Maiden Name Tillie
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-23-48 (month) (day) (year)
(c) Cemetery or crematory Wash. Bd.
Location Wash. Bd.

18 (a) Funeral director Jack Lewis Inc.
(b) Address 2445 Eutaw St.

19 FEB 22 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21 1948, at 6 25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 20 1948 to Feb. 21 1948, and that I last saw him alive on Feb 21 1948

Immediate cause of death: Hypertensive cardio-vascular disease & coronary thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gilbert M. Carouge M. D.
Address 6226 Everall Ave. Date signed 2-21-48

VS 150

G60434

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G60434 Registered No. 121

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Raspeburg, Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5601 North ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Allen Torbit

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 1st 1943

8. AGE: Years	Months	Days	If less than one day
4	6	20	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Robert A. Torbit

13. Birthplace Balto.

MOTHER 14. Maiden Name Dorothy M.

15. Birthplace Balto.

16 (a) Informant mother

(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/45 (month) (day) (year)

(c) Cemetery or crematory Providence

Location Balto Co. Md.

18 (a) Funeral director Hasselbrook Funeral Home

(b) Address 1401 Belair Rd.

FEB 22 1945 (a) (Date received by registrar) (b) Huntington Woodstock, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 February 1945, at 10:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-21 1945, to 2-21 1945 and that I last saw him alive on 2-21 1945

Immediate cause of death	Duration
Generalized peritonitis	
Due to acute gangrenous appendicitis, perforated	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2-21-45

Major findings of operation: Ruptured appendix

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Frank J. Brady, M.D.

Address Md. Gen. Hosp. Date signed 2-21-45 M. D.

X

G60435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G60435 Registered No.

1. PLACE OF DEATH: D of.
(a) Baltimore City, Maryland
(b) Street address 751 Dover St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 751 Dover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laddie Outlaw

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1915

8. AGE: Years	Months	Days	If less than one day
91			hr. min.

9. Birthplace N. C
(Town, county, and state)

10. Usual Occupation D
11. Industry or business

FATHER
12. Name Henry Out Law
13. Birthplace N. C

MOTHER
14. Maiden Name Effie Ward
15. Birthplace N. C

16 (a) Informant Robert Out Law
(b) Address 751 Dover St

17 (a) Removal (b) Date thereof 2/21/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Allanders N. C.
Location Allanders

18 (a) Funeral director Sarah L. Brown Son
(b) Address 1064 Monty mery St

19 (a) (b)
(Date rec'd by Registrar) Registrar

FEB 22 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/20 1948, at 11:40 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of Cervix

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Lubanski M.D.
Medical Examiner.
Date signed 2/20/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G60436

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G60436 Registered No. 122B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U.S. Marine Hospital, Balto., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 65 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 days

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County
(c) City or town New York
(If outside city or town limits, write RURAL and give town)
(d) Street No. 543 W. 129th St.
(If rural give location)
(e) Citizen of foreign country? unknown (Yes or No)
If yes, name country

3 (a) FULL NAME
Angel Marino Camean

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	187-05-6583

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Regina ?
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1906

8. AGE: Years	Months	Days	If less than one day
41	3	10	..... hr. ..... min.

9. Birthplace Spain
(Town, county, and state)
10. Usual Occupation Oiler
11. Industry or business Seafarer

FATHER
12. Name Rojero Camean
13. Birthplace Spain

MOTHER
14. Maiden Name Carman ?
15. Birthplace Spain

16 (a) Informant Records
(b) Address U.S. Marine Hospital, Balto. Md.

17 (a) Burial (b) Date thereof Feb 25-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Trees Forde City N. Y.

18 (a) Funeral director Essenforth Funeral
(b) Address 3911 Liberty Heights Ave

19 (a) FEB 23 1948 (b) Huntington Williams, M.D.
(Date received by registrar)

VS 150 hft

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21 19 48 at 4:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18 19 47 to 2/21 19 48, and that I last saw him alive on 2/21 19 48.

Immediate cause of death	Duration
Perforation of urinary bladder with pelvic abscess.	7 weeks
Contributing causes: Aspiration pneumonia, bilateral	3 or 4 days
Intestinal obstruction, partial.	4 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr Surgeon, Clinical Director, M.D.
Address U.S. Marine Hospital Balto., Md. Date signed 2/21/48

G60437

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G60437 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1530 Hanover St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1530 Hanover St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Pease Leonard

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widow

6 (b) Name of husband or wife Christopher C Leonard — 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8/1/1865

8. AGE: Years	Months	Days	If less than one day
82	6	18	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Alexander Pease
13. Birthplace Mass

MOTHER
14. Maiden Name Ann Smith
15. Birthplace Mass

16 (a) Informant Mrs C C Leonard
(b) Address 1530 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Road

18 (a) Funeral director J. Fahey Hanna
(b) Address 218 High St.

19 (a) Date received FEB 23 1948 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/19 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/11 1948, to 2/19 1948, and that I last saw her alive on 2/18 1948.

Immediate cause of death Hypertensive arteriosclerotic heart disease — Duration 2 yrs

Due to —

Due to —

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Deitel M.D.
Address 226 Hamilton St. Date signed 2/20/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C60438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

C60438 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2514 Harlem ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2514 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Alfred Crooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Mary J. Crook
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9 1884

8. AGE: Years	Months	Days	If less than one day
63	2	10	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Tank Wagon Salesman
11. Industry or business Standard Oil Co.

FATHER
12. Name Wm. A. Crooks, Sr.
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Claggett
15. Birthplace Md.

16 (a) Informant Mrs. Mary J. Crooks
(b) Address 2514 Harlem ave, Balto. Md.

17 (a) Burial (b) Date thereof 2/22/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Memorial Gardens
Location Liberty Road nr. Randallstown

18 (a) Funeral director C. Harry Weer
(b) Address Laytonsville, Md.

19 (a) 1949 (b) Clinton Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 1948, at 12 Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from 1946, to 2/19/1948, and that I last saw him alive on 2/18/1948.

Immediate cause of death Cardio Vascular Disease — Duration

Due to Arteriosclerosis

Due to

Other Conditions Arthritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stanton E. Martin M. D.
Address Randallstown Date signed 2/19/48

VS 150

G60439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45c

G60439 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 69 days
(e) Length of stay in Baltimore (yrs., mos., or days) 69 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Worcester
(c) City or town Ocean City (If outside city or town limits, write RURAL and give town)
(d) Street No. 104 N. Philadelphia Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Haskin Updegraff Deeley

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW I	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Lillian Justice Deeley
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1896

8. AGE: Years	Months	Days	If less than one day
51	5	9	..... hr. ..... min.

9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Charles R. Deeley
13. Birthplace Indiana

MOTHER
14. Maiden Name Laura Updegraff
15 Birthplace Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 23/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Balto Co.

18 (a) Funeral director John O. Mitchell Home
(b) Address 1900 Eutaw Place

19 (a) FEB 2 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 19 48, at 9:20A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 13 19 47 to Feb. 20 19 48, and that I last saw him alive on Feb. 20 19 48

Immediate cause of death Carcinoma squamous cell, left floor of mouth and left jaw with
Due to necrosis and hemorrhage
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

Duration
UNKNOWN

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 2/20/48 M. D.

660440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

660440 Registered No. 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hosp. Women Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Riderwood
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Margaret Katherine Stevenson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	widowed

6 (b) Name of husband or wife John Stevenson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-13-1874

8. AGE: Years	Months	Days	If less than one day
73	8	8	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Emanuel Hemmes
13. Birthplace York - Pa.

MOTHER
14. Maiden Name Sarah Weiser
15. Birthplace York - Pa

16 (a) Informant John Stevenson
(b) Address Riderwood - Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John C. Mitchell Sons
(b) Address 1900 Eutaw Pl.

19 (a) 2-22-1948 (Date rec'd by registrar) Clarence Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb - 21 - 1948, at 11:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb - 12 1948 to Feb - 21 - 1948 and that I last saw her alive on Feb - 21 - 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertensive Cardio-vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George A. Schlemmer M.D.
Address Hosp. Wom. Md. Date signed 2/24/48

VS 150

G60441

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G60441
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 313 Greenway
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 - 2
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 Greenway Apts
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME: Sadie V. Reamer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 19, 1860

8. AGE: Years 87 | Months 5 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Martinsburg, W. Va.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name William C. Reamer
13. Birthplace Pa.

MOTHER
14. Maiden Name Abbigail Mann
15. Birthplace Pa.

16 (a) Informant George W. Green
(b) Address 2708 Guilford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/48 (month) (day) (year)
(c) Cemetery ~~Greenmount~~ Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) FEB 22 1948 (Date rec'd by registrar) (b) 4 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20, 1948, at 12.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 3, 1947, to Feb. 20, 1948 and that I last saw her alive on Feb. 20, 1948:

Immediate cause of death: Cerebral Arteriosclerosis — Duration: Years? Years?
Due to ~
Due to ~
Other Conditions Chronic Myocarditis — Years.
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ~
(b) Date of occurrence ~ at ~ M
(c) Where did injury occur? ~
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ~ While at work? ~
(Specify type of place)
(e) Means of injury ~

23. Signature Frank M. Ogden M. D.
Address 2701 N. Calvert St. Date signed

VS 150

X

660442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

660442 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT ST.
(c) Hospital or institution: MERCY HOSP. 27-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL, and give town)
(d) Street No. 6129 RIDGE VIEW AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR ROSSITER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Lena Potts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN 10, 1873

8. AGE: Years	Months	Days	If less than one day
75	1	11	hr. min.

9. Birthplace ENGLAND (Town, county, and state)
10. Usual Occupation MARBLE WORKER
11. Industry or business

FATHER
12. Name JAMES ROSSITER
13. Birthplace ENGLAND

MOTHER
14. Maiden Name EMMA SNELLGROVE
15 Birthplace ENGLAND

16 (a) Informant ADM. SLIP.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto. Md.
18 (a) Funeral director John C. Mitchell & Sons
(b) Address 1400 Eutaw Place

19 (a) FEB 22 1948 (date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB 21 1948 at 6 46 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/16 1948 to 2/21 1948 and that I last saw him alive on 2/21 1948

Immediate cause of death CARDIO-RESPIRATORY FAILURE — Duration

Due to UREMIA

Due to SEPTICEMIA PYONEPHROSIS

Other Conditions CARCINOMA OF PROSTATE & METASTASIS
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: PYONEPHRITIS - CARCINOMA

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elden H. Pratt, M.D.
Address Mercy Hosp. Date signed 2/21/48

VS 150

G60443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G60443

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1629 E. 32nd street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 E. 32nd street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH COLLINS LUTTS

3 (b) If veteran, name war ------

3 (c) Social Security Account No. ------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widow

6 (b) Name of husband or wife William J. Lutts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 2, 1869

8. AGE: Years	Months	Days	If less than one day
78	4	18	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Peter Collins
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary O'Connor
15. Birthplace Ireland

16 (a) Informant Mr. Charles J. Lutts
(b) Address 1629 E. 32nd street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans & Son Inc
(b) Address 118 N. Mt. Royal Ave

19 (a) Feb 22 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 1948 at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1946 to 2-20-48 1948, and that I last saw h-r alive on 2-20-48 1948.

	Duration
Immediate cause of death: Pneumonia	10 day
Due to: Myocarditis Heart failure	20 day
Due to: Arterio-Sclerosis	10 yr.
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: ✓
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide none
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Wyatt Hooper
Address 30-34 Ellerslie Date signed 2-22-48

VS 150

G60444

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G60444
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 259 S. Ellwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 259 S. Ellwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth C. Appelt.

3 (b) If veteran, name war No

3 (c) Social Security Account No. None

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John J.

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Nov. 28 1873

8. AGE: Years 74 | Months 3 | Days 8 | If less than one day ..... hr. ..... min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER
12. Name Charles Punte
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Germany

16 (a) Informant John J. Appelt
(b) Address 259 S. Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 23 48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Blair Rd

18 (a) Funeral director Dippel Bros
(b) Address 1800 E Lombard St
Remington Williams, Mgr

19 (a) FEB 22 1948 (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 1948 at 12:15 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Feb. 5 1948 to Feb 20 1948 and that I last saw her alive on Feb. 20 1948.

	Duration
Immediate cause of death Coronary Thrombosis	acute
Due to Generalized Atherosclerosis + Chronic Hypertension	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Chas F. Steinglass M.D.

Address 700 E. Pratt St. Date signed 2/25/48

G60445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G60445 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town) 5
(d) Street No. 3113 NORTHWAY DRIVE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) **FULL NAME** JOSEPHINE A HAMMEL

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.:

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband ~~or wife~~: ALBERT E.
6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) SEPT 13 1918

8. AGE: Years 29 | Months 5 | Days 7 | If less than one day: hr. min.

9. Birthplace BALTIMORE, MARYLAND (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business HOME

FATHER
12. Name CAMILLO J. MUSCELLO
13. Birthplace ITALY

MOTHER
14. Maiden Name MARY C. MASTROCOLA
15. Birthplace BALTIMORE, MD.

16 (a) Informant HUSBAND
(b) Address 3113 NORTHWAY DRIVE

17 (a) entombment (Burial, cremation, or removal) (b) Date thereof 2/25/48 (month) (day) (year)
(c) Cemetery or crematory Loraine
Location

18 (a) Funeral director The Dignel Bros.
(b) Address 1800 E. Lombard St.

19 (a) (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 FEB 1948, at 11:07 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 16 FEB 1948, to 20 FEB 1948, and that I last saw her alive on 20 FEB 1948.

	Duration
Immediate cause of death: PSEUDO MUCINOUS CYSTADENOMA, OVARY WITH CARCINOMATOSIS, GENERALIZED	2 YRS
Due to	2 YRS
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: GENERALIZED CARCINOMATOSIS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert King Schoenbeler M. D.
Address md. Gen'l Hosp. Date signed 21 Feb 48

VS 159

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G60446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G60446

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 19 S. Chapel St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 19 S. Chapel St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Fritsch

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Aloysious
6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) Sept 26 1869

8. AGE: Years 79 | Months 4 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Aloysious Fritsch
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Banning
15. Birthplace Germany

16 (a) Informant George J. Fritsch
(b) Address 2816 Kentucky Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd

18 (a) Funeral director Dippel Bros
(b) Address 1800 E. Lombard St.

19 (a) FEB 22 1948 (Date rec'd by registrar) (b) Interment Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Febry 18 1948 to — 19—; and that I last saw h. alive on Feb. 18 1948.

Immediate cause of death: Congestive Heart Failure — Duration: about 6 months
Due to: arteriosclerotic Myocardial degeneration of the Heart.
Due to:
Other Conditions: /
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. Trausch M. D.
Address 1623 E. N. Ave. Date signed 2/20/48

VS 150

X

G60447

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G60447

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 913 N Monroe St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 913 N. Monroe St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Emma Shelly

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1870

8. AGE: Years 77 | Months 5 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James Shelly
13. Birthplace Hanover, Pa.

MOTHER
14. Maiden Name Mary Frederick
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Edith Shelly
(b) Address 913 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/48 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Baltimore, Md.

18 (a) Funeral director William J. Fickner & Sons
(b) Address North & Pennsylvania Aves

FEB 22 1948
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21, 1948, at 9 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 13 1948 to Feb 21 1948, and that I last saw her alive on Feb 20 1948

Immediate cause of death: Carcinoma Both Breasts.

Due to

Due to

Other Conditions: Lymphangitis Pt Sternum Chr. Myocarditis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George E. Shannon M.D.

Address 720 Mid-Atlantic Bldg Date signed 2/24/48

Pennington Williams Registrar

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G60448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G60448 ✓ Registered No. 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3408 Auchentoroly Terr.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-4
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3408 Auchentoroly Terr. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARGARET M. GRACE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1872

8. AGE: Years	Months	Days	If less than one day
75	8	13	hr. min.

9. Birthplace Middletown, Va. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name James W. Grace
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Callman
15. Birthplace Ireland

16 (a) Informant Mrs. Grace K. Hachman
(b) Address 3408 Auchentoroly Terr.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/23/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location Winchester, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 2/22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20, 1948, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1947 to 2/20 1948, and that I last saw her alive on 2/20 1948.

Immediate cause of death	Duration
(a) Left Cerebral Hemorrhage recurrent.	1 Wk.
Due to	
Due to	
Other Conditions Arteriosclerosis	7.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dagmar Malagia M. D.
Address 33 W. Hoffman St. Date signed

X

G60449 ✓ G60449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Av. & Keyworth Ave.
(c) Hospital or institution: The Children's Hospital School
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1y, 4mo, 22days
(e) Length of stay in Baltimore (yrs., mos., or days) 1yr. 4mo, 22days

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County
(c) City or town Poughkeepsie (If outside city or town limits, write RURAL and give town)
(d) Street No. 81 Innis Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Everbertha Gibson

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: —
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) 8/21/16
8. AGE: Years 31 | Months 5 | Days 1 | If less than one day — hr. — min.
9. Birthplace Poughkeepsie, New York. (Town, county, and state)
10. Usual Occupation Tabulating Machine Operator.
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb. 22, 1948 (month) (day) (year)
(c) Cemetery or crematory
Location Poughkeepsie N.Y.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) 22 Feb 48 (Date rec'd by registrar) (Signature of Registrar) Washington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 22nd - February 1948, at 6.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-3 1946, to 22 Feb 1948, and that I last saw her alive on 21 Feb. 1948.

Immediate cause of death: Coronary Thrombosis — Duration
Due to: Chronic Myocarditis.
Due to:
Other Conditions: Chronic Anterior Poliomyelitis

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence No at M
(c) Where did injury occur? No (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? No (Specify type of place) While at work?
(e) Means of injury None

23. Signature W. J. Hoover, Jr. M.D.
Address The Children's Hospital School, Baltimore, Md. Date signed 22 Feb 48

VS 3

93D

060450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 060450

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2202 Ashton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 - 3
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 Ashton St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret M. Scheffel

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: John J. Scheffel
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) February 20, 1876

8. AGE: Years 72 | Months — | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace: Germany (Town, county and state)
10. Usual Occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: ? Kaminsky
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: John Jost Scheffel
(b) Address: 2202 Ashton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-25-48 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Baltimore Md.

18 (a) Funeral director: George L. Schwab
(b) Address: 2101 Frederick Ave.

19 (a) FEB 23 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/22 1948 at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1940 to 2/22 1948 and that I last saw h[illegible] alive on 2/22 1948.

Immediate cause of death: Diabetes mellitus — Duration: 1 day

Due to:

Due to:

Other Conditions: Cerebral thrombosis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Benjamin Miller M. D.
Address: 670 Wilkens Ave Date signed: 2/22/48

60451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 13B

Registered No. 60451

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1912 E. MADISON ST.
(c) Hospital or institution: 7-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 25 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1912 E. MADISON ST.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES ANTHONY SUPIK

3 (b) If veteran, name war NO

3 (c) Social Security Account No. NO

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife EMMA H.
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) 5 APR 1880

8. AGE: Years	Months	Days	If less than one day hr.	min.
77	10	15		

9. Birthplace NALZOVY BOHEMIA, CZECH
(Town, county, and state)

10. Usual Occupation CLOTHING BUSINESS

11. Industry or business MANAGER-RETIRED

FATHER
12. Name JACOB SUPIK
13. Birthplace BOHEMIA, CZECH

MOTHER
14. Maiden Name MARY HRANAC
15. Birthplace BOHEMIA, CZECH

16 (a) Informant EMMA SUPIK
(b) Address 1912 E. MADISON ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-23-48 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BALTIMORE MD

18 (a) Funeral director FRANK CVACH & SON
(b) Address 600 N. CHESTER ST

19 FEB 28 1948 (Date rec'd by registrar) (b) Registrar Leighton Williams, Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 FEB 1948, at 4 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1947 to Feb 20, 1948, and that I last saw him alive on Febru 1948

Immediate cause of death	Duration
Pulmonary Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hugh J. Welch M. D.

Address 1123 - St Paul St Date signed

Hugh J. Welch X

660452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 660452

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 108 East Madison St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph S. CAD WALLADER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Clara Knight Cadwallader

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 5th 1881

8. AGE: Years	Months	Days	If less than one day
67	0	16 17	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Caretaker

11. Industry or business 108 E. Madison St.

FATHER
12. Name (Unknown) Cadwallader
13. Birthplace "

MOTHER
14. Maiden Name M. Caroline Lesser
15. Birthplace Unknown

16 (a) Informant Virginia Eckels
(b) Address 1634 Argonne Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) FEB 23 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 1948, at 9:15 A.M.

21. I certify that I took charge of the remains described above, held an Inspection ~~Autopsy~~ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ ~~cause~~ of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 2/21/48

VS 131

660453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

660453
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Cold Spring Lane
(c) Hospital or institution: Nursing Home Cold Spring Home 27-15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2101 W. Cold Spring Lane
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore, Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Philip Ringberg

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife -
6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr) July 26, 1869

8. AGE: Years	Months	Days	If less than one day
78	6	24	hr. min.

9. Birthplace Sweden (Town, county, and state)
10. Usual Occupation -
11. Industry or business -

FATHER
12. Name Theodore Ringberg
13. Birthplace Sweden

MOTHER
14. Maiden Name Marie Ringberg
15 Birthplace Sweden

16 (a) Informant Dept. of Welfare
(b) Address 327 St. Paul Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 23-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 FEB 23 1948 (Date rec'd by Registrar) Huntington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 1948, at 6.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1948 to Feb 20 1948 and that I last saw him alive on Feb 18 1948.

Immediate cause of death: Arteriosclerotic Heart Disease — Duration: 3 yrs.
Due to
Due to
Other Conditions: Parkinson's Disease — 5 yrs
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norman R. Keesman M. D.
Address 3803 Edmondson Ave Date signed 2/25/48

X

G60454 375706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

557

Registered No. G60454

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)

(d) Street No. 6531 St. Helena Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Chapman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-3-80

8. AGE: Years 67 | Months 11 | Days 18 | If less than one day hr. min.

9. Birthplace Ky (Town, county, and state)

10. Usual Occupation Coal Miner

11. Industry or business 400-14-1610

FATHER 12. Name Felton Chapman

13. Birthplace Ky

MOTHER 14. Maiden Name Ruth Galloy

15. Birthplace Ky

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/23/48 (month) (day) (year)

(c) Cemetery or crematory Combs

Location Combs, Kentucky

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

19 (a) 2-2-1948 (Date received by registrar) (b) [illegible] for William Cook

FEB

VS 150

MEDICAL CERTIFICATION 15

20. DATE OF DEATH Feb. 21 1948, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-14- 1948 to 2-21- 1948 and that I last saw h[illegible] alive on 2-21- 1948

Immediate cause of death: Question Carcinoma of Antrum

Due to: left

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: 1 year

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Douglas Council

Address Johns Hopkins Date signed 21 Feb 1948

X

660455 F 99885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660455

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3001 Ohio Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beverly B. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-4-44

8. AGE: Years 3 | Months 4 | Days 15 | If less than one day — hr. — min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name John T. Brown

13. Birthplace Md.

14. Maiden Name Adaline Snyder

15. Birthplace Md

16 (a) Informant John T. Brown

(b) Address [redacted] JOHNS HOPKINS HOSPITAL

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 2/23/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Frederick Ave

18 (a) Funeral director Geo. H. Leimbach

(b) Address 525 N. Eutaw Street

19 (a) FEB 23 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19-1948, at 5:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-18-1948, to 2-19-1948, and that I last saw her alive on 2-17 1948.

Immediate cause of death	Duration
Respiratory Cessation	
Due to Cerebral Hemorrhage	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation 2-5-48	
Major findings of operation: Spinal Air Injection - Negative	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Philip Brown M. D.

Address [redacted] Date signed 2-19-48

VS 150

660456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

Registered No. 660456

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1000 Caton Ave.

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 338 Gwynn Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME R. Donald Parker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Helen.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 65 | Months | Days 7 | If less than one day hr. min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual Occupation City Foreman

11. Industry or business

FATHER

12. Name John Parker

13. Birthplace Md.

MOTHER

14. Maiden Name Margaret Clark

15. Birthplace Md.

16 (a) Informant Helen Parker

(b) Address 338 Gwynn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/25/48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location

18 (a) Funeral director Chas P Sowell

(b) Address 2427 Edmondson Ave

19 (a) FEB 23 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/22/48 · 19 , at 8:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-22 1948 to 2-22 1948, and that I last saw him alive on 2-22 1948.

Immediate cause of death: Rupture of Dissecting Aneurysm of abdominal aorta —

Duration

Due to

Due to Arteriosclerotic Cardio-vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None performed

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature S. J. Venable, M. D.

Address St Agnes Hospital Date signed 2-22-48

VS 150

X

660457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 660457

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3701 2nd St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3701 2nd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ann Bowen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widow

6 (b) Name of husband or wife Carl C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5. 1871

8. AGE: Years	Months	Days	If less than one day: hr.	min.
76	9	16		

9. Birthplace Inland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Houston
13. Birthplace Inland

MOTHER
14. Maiden Name Mag.
15. Birthplace Inland

16 (a) Informant Margaret Mann
(b) Address 3701 2nd St.

17 (a) Burial (b) Date thereof 2/25/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Cross Brooklyn
Location Annapolis Blvd

18 (a) Funeral director Flynn & Flemming
(b) Address 1426 Light St.

19 FEB 23 1948 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21, 1948, at 11:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to Feb 21 1948, and that I last saw her alive on Feb. 20 1948.

Immediate cause of death	Duration
coronary occlusion	
Due to hypertensive cardio vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Philip W. Kuster, DMD

Address 302 Patapsco Ave Date signed M. D. Feb 22 '48

X Kuster

660458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 660458

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1422 Light St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1422 Light St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Maurice J. Flynn

3 (b) If veteran, name war — | 3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Teresa Flynn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 5 1889

8. AGE: Years 59 | Months 1 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business Funeral Director

FATHER
12. Name Daniel Flynn
13. Birthplace Balto Md

MOTHER
14. Maiden Name Mary Quillin
15. Birthplace Balto Md

16 (a) Informant Mildred A. Kelly
(b) Address 1422 Light St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-23-1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director E. J. Fanning & Son
(b) Address Lafayette & Wolfe Sts.

19 (a) Feb 23 1948 (Date rec'd by registrar) (b) Huntington Wilson Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 1948, at 7-45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19 48, to Feb. 20, 19 48 and that I last saw him alive on Feb. 20, 19 48.

Immediate cause of death Cardiac Failure
Due to Arteriosclerotic Heart Disease
Due to
Other Conditions Uremia.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. P. Friedman M.D.
Address 1319 Light St. Date signed 2/21/48

X

To be Approved by Medical Examiner

HL 115692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660459

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days): 2mos. 14 Days

(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County:

City or town: Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No.: 1516 Williams St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country:

24-4

3 (a) FULL NAME: Elizabeth Hubbard

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife:

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 6, 1860

8. AGE: Years	Months	Days	If less than one day
88	1	14	hr. min.

9. Birthplace: Balto, Md. (Town, county, and state)

10. Usual Occupation:

11. Industry or business:

FATHER

12. Name: Conrad Garbe (D)

13. Birthplace: ?

MOTHER

14. Maiden Name: Annie (D)

15. Birthplace: Germany

16 (a) Informant: B.C.H. Records

(b) Address: 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-23-1948 (month) (day) (year)

(c) Cemetery or crematory: Cedar Hill

Location: A. A. Co. Md.

18 (a) Funeral director: Flynn & Fleming

(b) Address: 1426 Light St.

19 (a) FEB 23 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 20 1948, at 12-P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 5 1947 to Feb. 20 1948 and that I last saw her alive on Feb. 20 1948

Immediate cause of death	Duration
Hypertensive Cardiovascular Disease with Congestive	yrs
Due to Heart Failure	2 days
Hypostatic Pneumonia Bilateral	24 hrs.
Due to Intertrochanteric fracture Left Femur	10 weeks
Other Conditions Generalized arteriosclerosis	yrs.

(Include pregnancy within 3 months of death)

Date of operation: Dec 6, 1947

Major findings of operation: fracture of Left Femur

of autopsy: none

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 24/4

(a) Accident, suicide, or homicide: Accident

(b) Date of occurrence: Dec 5, 1947 at 7 M

(c) Where did injury occur? Baltimore, (City or town) Md (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no

(e) Means of injury: Fell down steps inside

23. Signature: Rush B. Nutterville M. D.

Address: Balto City Hosp. Date signed: Feb 20, 1948

William G. Helfrich, M.D.

To Be Approved By M.E. Pet: Carl L. Rogers M.D.

660460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1313

Registered No. 660460

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 211
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 S. Eutaw St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ERNEST HARRISTON

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/17/1900

8. AGE: Years	Months	Days	If less than one day
48	0	4	hr. min.

9. Birthplace Winston Salem, N.C. (Town, county, and state)
10. Usual Occupation Junk-man
11. Industry or business

FATHER
12. Name Robert Harriston
13. Birthplace N.C.

MOTHER
14. Maiden Name Lydia Boyd
15. Birthplace N.C.

16 (a) Informant Lucy May Bruce
(b) Address 1010 So. Eutaw St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/23/48 (month) (day) (year)

(c) Cemetery or crematory
Location Winston Salem, N.C.

18 (a) Funeral director Chas. R. Law
(b) Address 802 Madison Ave.

19 (a) FEB 23 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21, 1948, at 3.50 A.M.

21. I certify that I took charge of the remains described above, held an autopsy – partial Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Acute Miliary Tuberculosis of Lungs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mellon M.D. Medical Examiner.
Date signed 2-21-48

VS 191

G60461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G60461

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1331- N. Gilmor St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimor
(If outside city or town limits write RURAL and give town)
(d) Street No. 1331- N. Gilmor St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maria Jenkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem.	Col.	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15 1898

8. AGE: Years	Months	Days	If less than one day
50	10	4	hr. min.

9. Birthplace Cumberlin Va
(Town, county, or state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Richard Wilson
13. Birthplace Va.

MOTHER
14. Maiden Name Effie Taylor
15. Birthplace Va.

16 (a) Informant Rev. Julia Branch
(b) Address 1327- N. Gilmor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-23-48 (month) (day) (year)

(c) Cemetery or crematory
Location Arbutus Cemetery

18 (a) Funeral director A. Halstead
(b) Address 918- Druid Hill Ave

19 (a) FEB 23 1948 (Date rec'd by registrar) (b) Certificate for Whole Life

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19- 1948 at 4:45 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2, 1948 to Feb. 19 1948. and that I last saw h[illegible] alive on Feb 18, 1948.

Immediate cause of death Coronary sclerosis — Duration 6 mos

Due to myocarditis — Duration 1 mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm E. S. Camper

Address 639 N. Carey Date signed 2-20-48

VS 150

660462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

660462 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2458 Callow Ave.
(c) Hospital or institution:

13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2458 Callow Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME KARL L. KUHN. (Karl L. Kuhn.)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mignon G. Kuhn.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1897.

8. AGE: Years	Months	Days	If less than one day
50	3	8	hr. min.

9. Birthplace New Orleans, La. (Town, county, and state)
10. Usual Occupation Salesman.
11. Industry or business

FATHER
12. Name Lambert Kuhn,
13. Birthplace ?

MOTHER
14. Maiden Name Lillian Haber,
15. Birthplace ?

16 (a) Informant Miss. Jane Kuhn,
(b) Address 2458 Callow Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2.23.48. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Baltimore, Md.

18 (a) Funeral director Harris Sonnheim & Son
(b) Address 1902 Eutaw Place.

19 (a) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21st. 1948 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1945 19 , to Yrs 1948 , and that I last saw h alive on Yrs 1948 .

Immediate cause of death Acute coronary thrombosis — Duration 10 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton B. Kirschbaum

Address 2320 Eutaw Place. Date signed M. 2/21/48. D.

Milton B. Kirschbaum

VS 150

460463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 460463

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene

(c) Hospital or institution: University of Maryland Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 34da.

(e) Length of stay in Baltimore (yrs., mos., or days) All Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore 1 (If outside city or town limits, write RURAL and give town)

(d) Street No. 726 N. Fremont Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mary Green (Bland)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Colored	Married x2

6 (b) Name of husband or wife Hosea Green (If alive, give age) (George Bland) years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years	Months	Days	If less than one day
35			hr. min.

9. Birthplace St marys co, md (Town, county, and state)

10. Usual Occupation Factory

11. Industry or business

FATHER 12. Name Edward Burden

13. Birthplace St marys co. md

MOTHER 14. Maiden Name Agnes Wilson

15. Birthplace St marys co. md

16 (a) Informant Mary L. Brown

(b) Address 657 W Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 23. 1948 (month) (day) (year)

(c) Cemetery or crematory Mt Calvery Cem

Location Brooklyn Md

18 (a) Funeral director Elroy B. Wilson

(b) Address 601 Bentley ave

19 (a) FEB 23 1948 (Date rec'd by registrar) Huntington Willi... registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20 1948, at 4:07 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1948 to Feb 20 1948, and that I last saw her alive on Feb 20 1948.

Immediate cause of death	Duration
Card resp Collapse	
Due to Subarachnoid hemorrhage	
Due to	
Other Conditions	over

(Include pregnancy within 3 months of death)

Date of operation Autopsy

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible]

Address Redwood & Greene Date signed 2/20/48 M. D.

VS 150

X

G60464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 169

G60464 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 13 2 Days
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3020 Kenwick Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Dewey Miller

3 (b) If veteran, name war: W.W.I

3 (c) Social Security Account No. 717-07-9236

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Abbie M. Miller
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1898

8. AGE: Years	Months	Days	If less than one day
49	5	29	....hr. ....min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Brakeman, conductor
11. Industry or business Pa. R.R.

FATHER
12. Name John R. Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Nellie McGonigle
15. Birthplace Ireland

16 (a) Informant Abbie M. Miller
(b) Address 3020 Kenwick Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-26-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Freeland, Balto. Co.

18 (a) Funeral director [illegible]
(b) Address 3615-17 Chestnut Ave

19 (a) FEB 23 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 1948, at 4:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to

Other Conditions Amp. Rt. arm, fracture sternum, fracture left tibia.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 12/5

(a) Date of injury 2-20-48 at 7:20 A.M.
(b) Where did injury occur? Penn. RR - St. Paul St. Bridge
(c) Did injury occur at home, on farm, industrial place, in public place? Public ~~Indus.~~ While at work? ~~yes~~
(d) Means of injury Struck by train

23. Signature [signature] M.D.
Medical Examiner
Date signed 2-23-48

VS 151

C60465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. C60465

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 149 Gilmor St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 149 Gilmor St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Sales

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col	Married

6 (b) Name of husband or wife Alberta Sales

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15 1902

8. AGE: Years	Months	Days	If less than one day
46	-	4	hr. min.

9. Birthplace Greenville S.C (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Sam Sales

13. Birthplace Greenville S.C

MOTHER 14. Maiden Name Lula Noah

15. Birthplace Greenville S.C.

16 (a) Informant Alberta Sales

(b) Address 149 Gilmor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 24, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Mrs Kate R. Williams

(b) Address 322 N. Schroeder St

19 (a) FEB 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13/48 19 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10/48 19 2/13/48 and that I last saw him alive on 2/13/48

Immediate cause of death (a) Lobar Pneumonia

Due to (b) Pneumonia

Due to (c) Congestive Bronchitis

Other Conditions Operation for hernia (Include pregnancy within 3 months of death)

Duration

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. L. Barksdale M. D.

Address 526 Cathedral Date signed 2/24/48

VS 150

660466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. 660466

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 834 Harlem Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 834 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Snowden.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	C	married

6 (b) Name of husband or wife Louise Snowden
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1877.

8. AGE: Years	Months	Days	If less than one day
70	10	29	hr. min.

9. Birthplace A. A. County Md. (Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name John Snowden.
13. Birthplace A. A. Co. Md.

MOTHER
14. Maiden Name Green
15. Birthplace A. A. Co. Md.

16 (a) Informant Louise Snowden.
(b) Address 834 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 23 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Katie Ridgeway
(b) Address 322 N. Schroeder St.

19 (a) FEB 23 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 1948 at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to Feb 20 1948 and that I last saw h alive on Feb 20 1948.

Immediate cause of death	Duration
Gastric Carcinoma	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 941 Hanover St Date signed 2-23-48

VS 150

660467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 660467

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1217 Wilmer Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 Wilmer Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva R. Sterling

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1895.

8. AGE: Years	Months	Days	If less than one day
52	10	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Emmett Jones
13. Birthplace Petersburg, Va.

MOTHER
14. Maiden Name Alice Ridley
15. Birthplace Petersburg, Va.

16 (a) Informant William E. Sterling
(b) Address 803 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 25, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) Feb. 23, 1948 (Date received by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-20- 1948 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-15-1948 to 2-20-1948, and that I last saw h[illegible] alive on 2-19-1948.

Immediate cause of death Chronic Cardio-Pancreas Renal Disease

Due to Myocardial failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1 year

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 600 Adams St. Signed 2/23/48

X

JAMES Bell

660468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

660468 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: Univ Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Frederick
(c) City or town Brunswick
(If outside city or town limits, write RURAL and give town)
(d) Street No. 15 South Maple Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME James Bell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mrs. James Bell —
6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) Sept 2 1879

8. AGE: Years 69 | Months 5 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Virginia (town, county and state)

10. Usual Occupation Pipe Fitter B&O.R.R.

11. Industry or business

FATHER
12. Name B. C. Bell
13. Birthplace Virginia

MOTHER
14. Maiden Name Florence Jacobs
15. Birthplace Virginia

16 (a) Informant Mrs Alice V. Bell
(b) Address Brunswick, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-26-1948 (month) (day) (year)
(c) Cemetery or crematory Hillcrest
Location Hillcrest Virginia

18 (a) Funeral director C. H. Zantz & Bro.
(b) Address Brunswick Maryland

19 (a) 2-23-1948 (Date rec'd by Registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/22/1948, at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5/1948 to 2/22/1948 and that I last saw him alive on 2/22/1948.

Immediate cause of death Probable cerebral metastases

Duration [redacted]

Due to Bronchogenic carcinoma, left lung

Due to

Other Conditions Empyema, left thorax, pneumothorax, right, complicated by bronchopleural fistula

(Include pregnancy within 3 months of death)

PURULENT

Date of operation 1/12/48

Major findings of operation: Bronchogenic carcinoma, left lung

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James K. Walker M.D.
Address University Hospital Date signed 2/23/48

VS 150

G60469

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46a

G60469
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 day
(e) Length of stay in Baltimore (yrs., mos., or days) 67 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore # 24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 139 S. Robinson St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Joseph G. Schmidt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: Wh. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Estelle Schmidt
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) July 4, 1880

8. AGE: Years 67 | Months 7 | Days 17 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Maintenance Man

11. Industry or business Chesapeake Cadillac Co.

FATHER
12. Name Leo Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Trunk
15. Birthplace Germany

16 (a) Informant Mrs. Estelle Schmidt
(b) Address 139 S. Robinson St, Baltimore 24.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 24-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director John G. Connelly
(b) Address 418 Eastern Ave

19 FEB 24 1948 (Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 1948, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 17 1948, to Feb. 21 1948, and that I last saw h[im] alive on Feb. 21 1948.

Immediate cause of death Coronary Occlusion — Duration: 8 hours.

Due to

Due to

Other Conditions Carcinoma of esophagus (Include pregnancy within 3 months of death) — 2 months+

Date of operation 2-16-48

Major findings of operation: Carcinoma of esophagus, middle third, inoperable

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert L. Johnson M. D.
Address Mercy Hospital Date signed 2-21-48

660470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 660470

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1223 Haubert St.
(c) Hospital or institution: 24-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No 1223 Haubert St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary R. Ellenberger

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 28, 1868

8. AGE: Years	Months	Days	If less than one day
80	-	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Peter Wendel
13. Birthplace Germany

MOTHER
14. Maiden Name
15 Birthplace —

16 (a) Informant Mrs. Mary Peterson
(b) Address 1223 Haubert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cemetery
Location Annapolis Road

18 (a) Funeral director Howard N. Bligh Jr.
(b) Address 4914 Belair Road

FEB 24 1948 (Date rec'd by registrar) Wilmington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/22 1948, at 3.30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/20 1947 to 2/22 1948 and that I last saw her alive on 2/21 1948.

Immediate cause of death:	Duration
Chronic Myocarditis	6 mos.
Due to Arterio Sclerosis	1 yr.
Due to Hypertension Arterial	1 yr.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. M. Mellott M. D.
Address 1279 Millard Date signed 2/23/48

X

G60471 HL. 116295

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G60471

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospital 6-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo. 20 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Virginia Hay

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Mark Hay
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb.22,1904

8. AGE: Years	Months	Days	If less than one day
44	-	1	hr. min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

MOTHER / FATHER
12. Name John Coffey
13. Birthplace N.C.
14. Maiden Name Nora May Coffey
15. Birthplace N.C.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location a. a. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 1948, at 1-15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 3 1948 to Feb.23 1948, and that I last saw her alive on Feb.23 1948.

Immediate cause of death Pulm. Tuberculosis — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. T. Binford M. D.
Address Balt City Hosp. Date signed 2-27-48

G60472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G60472 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1707 Homestead St
(c) Hospital or institution: 9.7.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 Homestead St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Minnie Wielert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Phillip J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan - 3 - 1867

8. AGE: Years 81 | Months 1 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Rudolf Bruns
13. Birthplace Germany

MOTHER
14. Maiden Name Mary ? ?
15. Birthplace Germany

16 (a) Informant Minnie Thalheimer
(b) Address 1707 Homestead St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair & Rd.

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) Huntington White Registrar, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1948, at 3 40 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from MAR 1947 to FEB 1948, and that I last saw h alive on FEB 23 1948.

Immediate cause of death ARTERIOSCLEROSIS — Duration 5 YRS

Due to

Due to HYPERTENSION, — 5 YRS

Other Conditions CAR. GAST. NEPH. — 1½ YRS

ASCITES
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis F Harwood M.D.
Address 3014 N Charles Date signed 2-23-48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G60473

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G60473

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2914 Clifton Park Terrace
(c) Hospital or institution: 8-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2914 Clifton Park Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Howard Reynolds Tipton

3 (b) If veteran, name war — 3 (c) Social Security Account No. NONE

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Anne E

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7 1859

8. AGE: Years 88 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace Howard Co Md (Town, county, and state)

10. Usual Occupation Mechanist Retired

11. Industry or business

FATHER
12. Name Wesley Tipton
13. Birthplace Harford Co Md

MOTHER
14. Maiden Name Matilda Manis
15. Birthplace Md

16 (a) Informant H H Tipton
(b) Address 2914 Clifton Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-26-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Fulton & Co
(b) Address 1217 E Lnd St

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) Arthur Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1948, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1948 to Feb 23 1948, and that I last saw h[illegible] alive on Feb. 23 1948

	Duration
Immediate cause of death: Generalized arteriosclerosis	5 t
Due to: Hypertensive Heart disease	1 yr.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Tipton M. D.
Address 2914 Clifton Park Terr Date signed 2/23/48

VS 150

8

X

G60474

F-8643

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

G60474
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1610 Linden Ave.
(c) Hospital or institution: 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Grace L. Newton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3rd. 1943

8. AGE: Years 4 | Months 4 | Days 19 | If less than one day hr. min.

9. Birthplace Caltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Archie D. Newton
13. Birthplace North Carolina

MOTHER
14. Maiden Name Callie C. Stevens
15. Birthplace Virginia

16 (a) Informant Callie C. Newton
(b) Address 1610 Linden Ave.

17 (a) Tuesday (Burial, cremation, or removal) (b) Date thereof 2/24/48 (month) (day) (year)
(c) Cemetery or crematory Louden Park
Location Baltimore, Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul Street

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) Hunter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22-1948, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1947, to 2-21-1948, and that I last saw h alive on 2-21-1948

Immediate cause of death Pneumonia

Due to Dessipation of mucous from mouth

Due to

Other Conditions Has had paralytic Condition Since age of 4 months

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: One week

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mrs Greenfield M. D.

Address 182 Eutaw Pl. 17 Date signed 2-23-48

VS 150

G60475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 83a

Registered No. G60475

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irene Susanne Gogel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced.~~
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age ___ years

7. Birth date of deceased (mo., day, yr.) Oct 24th 1879

8. AGE: Years	Months	Days	If less than one day
68	3	26	___ hr. ___ min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Musician

11. Industry or business Self

FATHER
12. Name Chas. H. M. Gogel
13. Birthplace Md.

MOTHER
14. Maiden Name Irene L. Simons
15 Birthplace Md.

16 (a) Informant M. V. Woolford
(b) Address 2918 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1207 St. Paul St.

19 (a) FEB 24 1948 (Date rec'd by registrar) Hunting Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20th 1948, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25- 1948 to Feb. 19 1948 and that I last saw her alive on Feb 19 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Adv. arteriosclerosis	
Due to	
Other Conditions Uremia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis Ignatz M.D.
Address 1700 Eutaw Pl. Date signed Feb. 23d 1948

VS 150

X

C60476

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. C60476

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2618 Greenmount Ave
(c) Hospital or institution: 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2618 Greenmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Davis Ball

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband or wife: Harry C. Ball
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26th 1867

8. AGE: Years 80 | Months 10 | Days 25 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business At Home

FATHER
12. Name James Baxley
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary Frances ?
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Elizabeth German
(b) Address 2618 Greenmount Ave

17 (a) Burial (b) Date thereof 2/24/48
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ M. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) FEB 24 1948 (b) ~~Registrar~~ Livingston Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21st 1948, at 11 45/2 M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1947 to Feb 21 1948, and that I last saw her alive on Feb 18. 1948.

Immediate cause of death	Duration
Myocardial Insufficiency	5 days
Due to Myocarditis	6 mos
Due to Senile Arteriosclerosis	5 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas F. White M.D.
Address 582-E22-St Date signed 2/25/48

X

~~C60477~~ C60477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C60477 / 480

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3904 Hanover St
(c) Hospital or institution: 25-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 25 Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3904 Hanover St
(If rural give location)
(e) Citizen of foreign country? No, (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth a. Henderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~: Jas. S. Henderson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 27 - 1884

8. AGE: Years 63 | Months 5 | Days 26 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph D. Johnson
13. Birthplace Maryland

MOTHER
14. Maiden Name Hanna Posey
15. Birthplace Maryland

16 (a) Informant Mrs Edna Tanner
(b) Address 3904 Hanover St 25

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Manjemoy Baptist Cem
Location Manjemoy, Md

18 (a) Funeral director Mitton & Schilling
(b) Address 3914 Hanover St 26

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 1948 4.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1947 to Feb 22 1948, and that I last saw h[er] alive on Feb 22 1948.

Immediate cause of death	Duration
generalized carcinomatosis	
Due to	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C W Kuntz MD
Address 302 Patapsco Av Date signed Feb 25 23

VS 150

48

G60478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G60478 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Williams & Carlon Aves
(a) Baltimore City, Maryland
(b) Street address ~~3331 Alto. Rd. 16~~
(c) Hospital or institution: St. Agnes 157
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3331 Alto. Rd. 16
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret C. Pendergast

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-1375

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 20 1903

8. AGE: Years 44 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Telephon Operator

11. Industry or business

FATHER
12. Name John Pendergast
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Gank
15. Birthplace Md.

16 (a) Informant Mrs. Anna M. Brennan
(b) Address 3331 Alto Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-26-1948 (month) (day) (year)
(c) Cemetery or crematory St. Peter's Catholic
Location Oakland, Md.

18 (a) Funeral director J. Howard Strong
(b) Address 3207 W. North Ave

19 FEB 24 1948 (Date rec'd by Registrar) Huntington for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 1948, at 5 in A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1948 to 2/23 1948, and that I last saw h-- alive on 2/23 1948.

Immediate cause of death: Carcinomatosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address St. Agnes Hosp. Date signed 2/24/48

VS 150

C60479

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

C60479 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 28-2
(b) Street address Raynor & Dukeland Ave.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3503 Plateau Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA T STAUFFER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Wm. F. Stauffer
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr) Sept. 2, 1893

8. AGE: Years	Months	Days	If less than one day
54	5	20	hr. min.

9. Birthplace Hagerstown, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name W. A. Spielman
13. Birthplace Funkstown, Md.

MOTHER
14. Maiden Name Susan Talbert
15. Birthplace Maryland

16 (a) Informant Mrs. Wm. F. Stauffer
(b) Address 3503 Plateau Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Feb. 24, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Millie Lamotray
(b) Address 4510 Liberty Heights Ave.

19 FEB 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 22 1948, at 8:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-21-1948 to 2-22 1948, and that I last saw her alive on 2-22 1948.

Immediate cause of death CEREBRO-VASCULAR ACCIDENT — Duration

Due to CEREBRAL ARTERIO-SCLEROSIS

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Kurtzitakey M. D.
Address West Baltimore General Hosp. Date signed 2/22/48

VS 150

X

660480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 138

660480 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5218 York Road
(c) Hospital or institution: — 27-11
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5218 York Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Frances Smith

3 (b) If veteran, name war

3 (c) Social Security Account No. 121907849O

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25, 1889

8. AGE: Years	Months	Days	If less than one day
58	10	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business —

FATHER
12. Name Thomas J. Smith
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Eleanor A. Gordon
15. Birthplace Richmond, Va.

16 (a) Informant Mrs Eleanor Smith
(b) Address 5218 York Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 26, 1948 (month) (day) (year)

(c) Cemetery or crematory [illegible]
Location Baltimore, Md. Balto. Nat'l Cem.

18 (a) Funeral director Miles Lamond
(b) Address 1003 E. Baltimore St.

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) [illegible] for Williams [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 1948, at 7:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946, to Feb 22 1948, and that I last saw [illegible] alive on Feb 22 1948.

Immediate cause of death	Duration
Cachexia	1 mo.
Due to Bilateral pulmonary tuberculosis	5 yr.
Due to	
Other Conditions —	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation: —	
of autopsy: —	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frederick J. Hellmer, M.D.
Address 6100 York Road Date signed Feb 23 48

(660481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. 660481

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 8-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2806 E. Federal St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET J. Freburger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 30, 1924

8. AGE: Years	Months	Days	If less than one day
23	3	21	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation house wife
11. Industry or business

MOTHER FATHER
12. Name George W. Diering
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Sophia E. Heinze
15. Birthplace Baltimore Md.

16 (a) Informant William A. Freburger
(b) Address 2806 E. Federal St.

17 (a) Burial (b) Date thereof 2/24/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) FEB 24 1948 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20, 1948, at 6.14 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to Illuminating Gas

Due to

Other Conditions Pregnancy 3 months
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-20-48 about 5 a. M. 2807 E. Federal St.
(b) Where did injury occur? Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Basement 4 burners and oven on, unlit

23. Signature Emil Beyer M.D.
Medical Examiner.
Date signed 2-20-48

C60482

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C60482

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland.
(b) Street address 1734 N Broadway
(c) Hospital or institution: B.C.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1734 N Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr Harry D. P. Scheuerman

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Katherine L Scheuerman

6 (b) Name of husband or wife

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) June 12 1884

8. AGE: Years	Months	Days	If less than one day
63	7	11	..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business Dentist

FATHER
12. Name Fred K. W. Scheuerman
13. Birthplace Balto

MOTHER
14. Maiden Name Emma S Meyer
15. Birthplace Germany

16 (a) Informant Harry D. P. Scheuerman
(b) Address 1734 N Broadway

17 (a) Burial (b) Date thereof Feby 25 -
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2108 Pleasant St

19 (a) FEB 24 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 23 1948 at 6:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1947 to Feb 23 1948 and that I last saw him alive on Feb. 23 1948.

Immediate cause of death Cerebral Hemorrhage — Duration 2 days

Due to Cardiovascular arteriosclerosis — 2 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph L. Valentine M.D.

Address 170 W Broadway Date signed 2/23/48

VS 150

G60383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G60383

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 422 N Luzerne Ave
(c) Hospital or institution: 6-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 422 N Luzerne Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nannie J Morrow

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 1868

8. AGE: Years	Months	Days	If less than one day
79	10		hr. min.

9. Birthplace Pepsue
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name John R Morrow
13. Birthplace Pa

MOTHER
14. Maiden Name Winters
15. Birthplace Pa

16 (a) Informant Mrs Margaret Wallace
(b) Address 422 N Luzerne

17 (a) Burial (b) Date thereof Feb 24/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn
Location Balto Co Md

18 (a) Funeral director Welsh Funeral Home
(b) Address 2008 Orleans St

FEB 24 1948
(Date rec'd by Registrar)

(b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1948, at 4 28 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1st 1945 to Feb. 21 1948, and that I last saw her alive on Feb. 21 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Arteriosclerosis Hypertension	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation No
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James F Waite M. D.
Address 472 Easton Ave Date signed Feb 28/48

VS 150

Baltimore 24, Md

G60484 Asst Room

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G60484

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: 15.4
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2123 Herbert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mabel A. Welling

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~
Female	White	Married

6 (b) Name of husband Clinton G. Welling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1st 1888

8. AGE: Years	Months	Days	If less than one day
59	10	20	hr. min.

9. Birthplace Union Mills Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER 12. Name John Stansbury
13. Birthplace Md.

MOTHER 14. Maiden Name Florence Townsend
15. Birthplace Md.

16 (a) Informant Clinton G. Welling
(b) Address and JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/25/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) FEB 24 1948 (Date received by Local Reg.) (b) Huntington Williams (Signature of Local Reg.)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 1948, at 7.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased ~~from~~ 2/21/47 19 to 19, and that I last saw her alive on 2/21 1948

Immediate cause of death	Heart failure	Duration 1 hr.
Due to	Arteriosclerotic heart disease	2 y.
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Victor A. McKusick M. D.
Address 1 Wyatt Pl. Date signed 7/...

Earl Kay M.D.

VS 150

660485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. 660485

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Harford Rd.
(c) Hospital or institution: Harford Nursing Home 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1633 E. 30th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Otilie Martinek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or ~~wife~~ Albert Martinek
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1896

8. AGE: Years	Months	Days	If less than one day
51	11 10	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Alois Pokorny
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Antonia Kacerovsky
15. Birthplace Czechoslovakia

16 (a) Informant Albert F. Martinek
(b) Address 1633 E. 30th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/48 (month) (day) (year)
(c) Cemetery or ~~cemetery~~ Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-3-5 E. Madison Street

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) Administrator Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 1948, at 8P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1946, to Feb 20 1948, and that I last saw her alive on Feb 20 1948.

	Duration
Immediate cause of death Intestinal Obstruction	1 week
Due to Carcinoma - stomach	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2/9/48

Major findings of operation: Carcinoma - stomach

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis F. Klein M. D.
Address Date signed 2/25/48

VS 150

G60486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

Registered No. G60486

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 7-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 712 N. Luzerne Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Huber, Lawrence James Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Anna Hammerbacher Huber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1881

8. AGE: Years	Months	Days	If less than one day
67	1	16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business U.S. Post Office

FATHER
12. Name Huber
13. Birthplace unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Miss Katherine Huber - daughter
(b) Address 712 N. Luzerne Avenue

17 (a) Burial (b) Date thereof 2/27/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Road, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-3-5 E. Madison Street

19 (a) FEB 24 1948 (b) Registrar
(Date rec'd by registrar)

FEB 24 1948
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Feb 1948, at 10 35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 18 Feb 1948 to 23 Feb 1948, and that I last saw him alive on 23 Feb 1948

Immediate cause of death	Duration
Bronchogenic carcinoma, rt lower lobe bronchus	about 1 year
Due to with metastasis to esophagus + liver	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marvin M. Davis
Address Sinai Hosp Date signed 2-23-48

X

G60487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G60487 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3311 Abell, Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Talbot
(c) City or town Bozman, Md, Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Mr. Thomas M. Cooper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1863

8. AGE: Years	Months	Days	If less than one day
84	10	8	hr. min.

9. Birthplace Bozman, Md (Town, county and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name Thomas F. Bridges
13. Birthplace Bozman, Md

MOTHER
14. Maiden Name Deborah Ball
15. Birthplace Bozman, Md

16 (a) Informant Miss Ethel Cooper
(b) Address 3311 Abell, Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 26, 48 (month) (day) (year)
(c) Cemetery or crematory ##### Bozman, Md
Location

18 (a) Funeral director John O. Mitchell Son, Inc,
(b) Address 1900 Eutaw Place,

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 25 19 48, at 8.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 22 1947 to Feb 23 1948. and that I last saw her alive on Feb 23 1948.

Immediate cause of death	Duration
Myocardial insufficiency	Birth
Due to Arteriosclerotic Cardiac disease	2
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: —
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature W. H. Smith M. D.
Address 3429 Chestnut, Ave Date signed

VS 150.

C60388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33B

Registered No. C60388

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 667 W. Barre Street
(c) Hospital or institution: Home 22-V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) -?-

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 667 W. Barre Street
(If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME Chin Chuck

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Chinese	?

6 (b) Name of husband or wife: ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1869

8. AGE: Years	Months	Days	If less than one day
about 79	?	?	hr. min.

9. Birthplace probably China (Town, county, and state)
10. Usual Occupation Laundryman
11. Industry or business Laundry

FATHER
12. Name ? ? ?
13. Birthplace China

MOTHER
14. Maiden Name ? ?
15. Birthplace China

16 (a) Informant Mr. Bock Ark (friend)
(b) Address 110 N. Liberty Street, City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 24 48 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn, Maryland

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Avenue, City #1.

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 1948 at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 20 1948 to Feb. 21 1948 and that I last saw h alive on Feb. 20 1948

Immediate cause of death	Duration
Influenza	10 days
Due to Unknown	
Due to	
Other Conditions Malnutrition + Senile Debility	Unknown

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ronald W. Gainey M. D.
Address 567 W. Hamburg St. Date signed 2/23/48

VS 150

G60489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G60489

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2 South Fulton Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County Lycoming
(c) City or town Montgomery Pa (If outside city or town limits, write RURAL and give town)
(d) Street No. 46 N. Main St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cordelia Miller Harman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife John Calvin Harman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28 1864

8. AGE: Years 83 | Months 10 | Days 25 | If less than one day hr. min.

9. Birthplace Berwick Pa (Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER
12. Name
13. Birthplace Pa

MOTHER
14. Maiden Name
15 Birthplace Pa

16 (a) Informant
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-25-48 (month) (day) (year)
(c) Cemetery or crematory Montgomery Co Cemetery
Location Pennsylvania

18 (a) Funeral director Earl K. Wolfersteig Funeral Home
(b) Address 403 E. 25th St

19 FEB 24 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 1948, at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17 1947 to Feb 23 1948, and that I last saw him alive on Feb 23 1948.

Immediate cause of death	Duration
Coronary Thrombosis	5 days
Due to arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Francis W. Gluck M. D.
Address 3406 St Paul St Date signed 2/24/48

660490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 660490

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1233 W. Lafayette Ave.
(c) Hospital or institution: 16-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1233 Lafayette ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Nora White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife George E. White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 10. 1875

8. AGE: Years	Months	Days	If less than one day
73	11	10	hr. min.

9. Birthplace Charles Co. Md
(Town, county, and state)
10. Usual Occupation at Home
11. Industry or business

FATHER
12. Name Benjamin Locke
13. Birthplace Md

MOTHER
14. Maiden Name Annie Livers
15. Birthplace Md

16 (a) Informant Maggie Martinez
(b) Address 1233 W. Lafayette ave

17 (a) Burial (b) Date thereof 2-25-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A. Davis
(b) Address 142 N. Stricker St.

19 (a) FEB 24 1948 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 1948, at 2.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-17 1948 to 2-20 1948 and that I last saw h[illegible] alive on 2-19-1948

	Duration
Immediate cause of death Coronary occlusion	2 days
Due to Coronary Sclerosis	one year
Due to myocarditis	2 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John & J. Campen M. D.
Address 639 N. Carey St Date signed 2-23-48

V S 150

60491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

60491 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 Baker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Emma M. Burke

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife JAMES C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1870

8. AGE: Years (70) 78 | Months 0 | Days 0 | If less than one day ..... hr. ..... min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name GEORGE KEPPEL
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant HOSPITAL RECORDS
(b) Address "

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/25/48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PK.
Location BALTIMORE, MD

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address BALTIMORE, MD

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 1948 at 5:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D. Medical Examiner.
Date signed 2-23-48

660492 BC = 48-03937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660492

161a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) ~~Street address~~ Hospital for Women of Md
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Millersville
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Ewell.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	W	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/24/48

8. AGE: Years	Months	Days	If less than one day
—	—	1	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name George Walther Ewell
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Claire Lucille Talbert
15. Birthplace Balto. Md

16 (a) Informant Mrs. George W. Ewell
(b) Address Millersville, Md.

17 (a) BURIAL (b) Date thereof 2/24/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory DRUID RIDGE
Location PIKESVILLE, MD.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto. MD.

19 (a) FEB 24 1948 (b) Registrar for Williamsville, Md.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22 1948, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 22 1948 to Feb. 22 1948 and that I last saw him alive on Feb. 22 1948

Immediate cause of death	Duration
Atelectasis.	
Due to Unknown Cause	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature V. C. Kelly M. D.
Address Woman's Hospital Date signed 2-23-48

G60493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G60493 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4515 GARRISON BLVD.
(c) Hospital or institution: N-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3609 LIBERTY HGTS. AVE.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME HELEN GEORGETTE RIDER KEEN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife RICHARD M. KEEN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 15, 1879

8. AGE: Years	Months	Days	If less than one day
69	1	17	hr. min.

9. Birthplace EMMITTSBURG, MD.
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name GEORGE M. RIDER
13. Birthplace EMITTSBURG, MD.

MOTHER
14. Maiden Name ELLEN WEIRECK
15. Birthplace LITTLESTOWN, MD

16 (a) Informant MR. RICHARD M. KEEN
(b) Address 3609 LIBERTY HGTS AVE

17 (a) BURIAL (b) Date thereof 2/25/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory DRUID RIDGE
Location PIKESVILLE, MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTIMORE, MD.

19 (a) FEB 24 1948 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 350

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/22/48 19 , at 9:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 8 1948, to Feb 22 1948, and that I last saw h. alive on Feb 21 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 wks
Due to	
Due to Pernicious Arteriosclerosis	1 yr
Other Conditions Hypertension	1 yr

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Thomas J. Mertz M.D.
Address 532 E 22nd St Date signed 2/23/48

X

660494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

660494 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 GREENSPRING AVE
(c) Hospital or institution: K-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3520 GREENSPRING AVE.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME SOPHIE GRUND.

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband ~~or wife~~: FRITZ
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): JAN 2, 1883

8. AGE: Years 65 | Months 1 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace: GERMANY
(Town, county, and state)

10. Usual Occupation: HOUSEWIFE
11. Industry or business: —

FATHER
12. Name: AUGUST HEISE
13. Birthplace: GERMANY

MOTHER
14. Maiden Name: AUGUSTA WARNEKE
15. Birthplace: GERMANY.

16 (a) Informant: HUSBAND
(b) Address: 3520 GREENSPRING AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/25/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~: LORRAINE
Location: BALTO. CO., MD.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: BALTIMORE, MD.

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) [illegible] Registrar

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/24/48 19— at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-27 1948 to 1-24 1948 and that I last saw h[illegible] alive on 2/22 1948.

Immediate cause of death: Myocardial failure
Due to: Hypertension
Due to: —
Other Conditions: —
(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation: —
of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature H. D. Franklin M. D.
Address 1123 St Paul St Date signed 2-25-48

H. D. Franklin X

660495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660495

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 509 W. LEXINGTON ST. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME GEORGE F. KAMTMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) ~~Single, married, widowed, or divorced~~ WIDOWED

6 (b) Name of husband or wife HELEN B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 5, 1882

8. AGE: Years 65 | Months 8 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation CATERER

11. Industry or business SELF.

MOTHER / FATHER

12. Name AUGUST F. KAMTMAN

13. Birthplace BALTIMORE, MD.

14. Maiden Name ANNA GRAUER

15. Birthplace BALTIMORE, MD.

16 (a) Informant MR. BERNARD KAMTMAN

(b) Address 14 ST. MARTINS R.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/26/48 (month) (day) (year)

(c) Cemetery or crematory PARKWOOD

Location BALTO. CO. MD.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address B[illegible] MD

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22 1948 at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-14 1948 to 2-22 1948 and that I last saw h[illegible] alive on 2-22 1948

Immediate cause of death CARDIAC FAIL- URE — Duration

Due to CEREBRAL EMBOLI

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. G. Mancuso Jr. M. D.

Address [illegible] Date signed 2-22-48

VS 150

C60496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94 ✓

Registered No. C60496

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital. 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 727- E. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Warren M. Weigel.

3 (b) If veteran, name war

3 (c) Social Security Account No. 205-03-1213

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace Penna.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Union News Stand

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs. Varley
(b) Address 727 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 24th 1948 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Fredrick Road

18 (a) Funeral director Leo S. Levin
(b) Address 1701-03 N. Patterson Park Ave

19 (a) 2-24-1948 (Date rec'd by registrar) Written for Williams Mfg. Co. Baltimore Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18, 1948, at 5.40 P M

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions Generalized A.S.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil C. Roth, M.D.
Medical Examiner

Date signed 2-19-48

VS 151

660497

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Registered No. 660497

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1837 N. Durham St.
(c) Hospital or institution: 8.5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1837 N. Durham St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie E. Alexander

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16th 1867

8. AGE: Years 80 | Months 6 | Days 6 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name John Alexander

13. Birthplace Md

14. Maiden Name Minnie Krauss

15. Birthplace Md

16 (a) Informant Seemon Sr. Alexander

(b) Address 1837 N. Durham St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 25th 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Frederick Road

18 (a) Funeral director Leo F. Cook

(b) Address 1701-03 N. Patterson Park Ave

19 Date rec'd by registrar Feb 24 1948 (Local registrar) Frederick for Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22nd 1948, at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1946, to Feb 22 1948.
and that I last saw her alive on Feb 21 1948

Immediate cause of death
Acute Dilatation
Due to Intersusception
Cecum
Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 Days
2 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. K. Grossman M.D.

Address 1212 N. Patterson Date signed 2-23-48

VS 150

Grossman Pharmacy

C60398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C60398 Registered No.

BC 48-03950 159

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 403 North Mount Street
(c) Hospital or institution: 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 29

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 403 North Mount Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thelma Booger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 29 1948

8. AGE: Years	Months	Days	If less than one day
		29	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name James Booger
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Thelma Randtree
15. Birthplace Baltimore Maryland

16 (a) Informant Mrs Randtree
(b) Address 408 East Mount Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof February 4, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cemetery
Location Baltimore City

18 (a) Funeral director Joseph A. Sivick
(b) Address 661 West Baltimore Street

19 (a) FEB 24 1948 (Date received) (b) Thurston Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION 48

20. DATE OF DEATH Feb 23 1948, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24 1948 to Feb 23 1948 and that I last saw her alive on Feb 23 1948.

Immediate cause of death Premature Birth — Duration

Due to

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. W. Rectenwald, M.D.
Address 412 N. Fulton Ave Date signed 2/23/48

C60499

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

C60499 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2100 Herbert St
(c) Hospital or institution: 15-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2100 Herbert St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ella Jane Kane

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Edward Kane
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 16 1850

8. AGE: Years	Months	Days	If less than one day
78	3	5	hr. min.

9. Birthplace Woodlawn Balto Co. Md (Town, county and state)
10. Usual Occupation House Duties
11. Industry or business

FATHER 12. Name George Temple.
13. Birthplace Woodlawn Balto Co Md

MOTHER 14. Maiden Name Caroline Fleetwood
15. Birthplace Sussex Co England.

16 (a) Informant Mrs Della Pentland
(b) Address 1948 Ridgehill ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 24 1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Baltimore Co. Md

18 (a) Funeral director Maune Cook Syfer
(b) Address 1600 W. North Ave.

19 (d) FEB 24 1948 (Date rec'd by registrar) (b) Frantz & Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1948 at 12:20 M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to Feb 24 1948
and that I last saw deceased alive on Feb 21 1948

Immediate cause of death: Uremia Hypocondition Acute Hypocondition c Failure — Duration 1 week 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Coleman M.D.
Address 1921 W North Date signed 2/25/48 M. D.

X

660500 BC-48-04046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 660500

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 818 E 22nd St
(c) Hospital or institution: Home 9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town BALTIMORE, MD
(If outside city or town limits, write RURAL and give town)
(d) Street No. 818 E 22ND ST
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Baby. Sears. 48-04046

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Infant

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) ~~1 hr.~~ (12 weeks) 2/24/48

8. AGE: Years	Months	Days	If less than one day
(Newborn)			..... hr. ..... min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation .....
11. Industry or business

FATHER
12. Name William R. Sears.
13. Birthplace Bowie, MD.

MOTHER
14. Maiden Name Elizabeth Knopp.
15. Birthplace Hartford Co. MD.

16 (a) Informant Mrs. Elizabeth Sears
(b) Address 818 E 22nd St.

17 (a) BURIAL. (b) Date thereof 2 24 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL
Location RITCHIE HIGHWAY
18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST. -30
19 (a) FEB 24 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 Feb 1948, at ~~5~~ 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 23 Feb 1948, to 24 Feb 1948, and that I last saw h[illegible] alive on 24 Feb 1948

Immediate cause of death Cardiac failure ..... Duration .....
Due to Prematurity (12 weeks) .....
Due to ....
Other Conditions ....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....
23. Signature H. B. Chandler M. D.
Address 11 E. Chase St Date signed 24 Feb 48.

VS 150

660501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

Registered No. 660501

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 18-1
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 28 N. Poppleton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Vernon Johnson Harris

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24, 1933.

8. AGE: Years	Months	Days	If less than one day
14	9	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Vernon Harris.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mildred Johnson.
15. Birthplace Baltimore, Md.

16 (a) Informant Hattie Brady
(b) Address 105 N. Amity St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 24, 1948 (month) (day) (year)
(c) Cemetery or crematory Osborne
Location Howard County, Md.

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N. Schroeder St.

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) Kate R. Williams M.D. Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19, 1948, at 9.15 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Stab wound of chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-19-48 at about 8.30 P. M.
(b) Where did injury occur? Lexington & Poppleton St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Sharp instrument

23. Signature [signature] M.D. Medical Examiner.
Date signed 2-20-48

660502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

Registered No. 660502

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2225 Gough st
(c) Hospital or institution:
Home 1-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2225 Gough st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine E. Lipka LIPKA

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	married

6 (b) Name of husband George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1 - 1883

8. AGE: Years	Months	Days	If less than one day
64 65	11	21	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation None-at-present

11. Industry or business

FATHER
12. Name Andrzej Stanek
13. Birthplace Poland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Poland

16 (a) Informant George Lipka
(b) Address 2225 Gough st

17 (a) Burial (b) Date thereof 2-25-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore Md

18 (a) Funeral director George A. Weber
(b) Address 705 S Ann st

19 FEB 24 1948 (b) Huntington Williamsport
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22nd 1948, at 3:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1943 to Feb-22 1948, and that I last saw h. alive on Febr 21 1948.

Immediate cause of death	Duration
(a) Acute Coronary Thrombosis	6 days
Due to (b) Coronary Arteriosclerosis Chr. Endocarditis + Myocarditis	5 yrs
Due to	
Other Conditions Cerebral Thrombosis	3 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 705 E. Pratt Date signed 2/24/48 M. D.

V S 150

660503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

660503 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 12-S
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 413- McAllister St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LAURA GARDNER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William Gardner Sr.

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Feb 18, 1896

8. AGE: Years 52 | Months - | Days - | If less than one day ____ hr. ____ min.

9. Birthplace King Williams Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Ranall Moore
13. Birthplace King Willams Va.

MOTHER
14. Maiden Name Sally Moore
15. Birthplace King Williams Va.

16 (a) Informant William Gardner Jr.
(b) Address 413 McAllister Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 24-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calavary
Location Brooklyn Md.

18 (a) Funeral director Joseph L. Russ
(b) Address 1200 McCulloh Street

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18, 1948 at 9.10 P M

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular renal disease.
Acute pulmonary edema.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 2-19-48

X

No. 060504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54 B

Registered No. 060504

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2908 Huntingdon Ave
(c) Hospital or institution: 12-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 Huntingdon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME A. Earl Hines.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-09-9875

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married.

6 (b) Name of husband or wife Betty Lee Hines.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2 1918

8. AGE: Years	Months	Days	If less than one day
29	6	20	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Clerk.
11. Industry or business Bethlehem Steel.

FATHER
12. Name Albert Hines.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Addie P. Royston
15. Birthplace Maryland.

16 (a) Informant Betty Lee Hines.
(b) Address 2908 Huntingdon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 25/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director Christian E. Donovan
(b) Address 3615-17 Chestnut Ave

19 FEB 24 1948 (Date rec'd by registrar) (Huntington Williams M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22, 1948, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/25 1946 to 2/22 1948 and that I last saw h not alive on 2/19 1948

Immediate cause of death (CAUSE PRINT) Sarcoma of canda - Pituitary & mbry metastases 2 lungs — Duration 2 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation January 1, 1946

Major findings of operation: Sarcoma of canda - Pituitary

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ed Jamison M. D.
Address Medical Arts Bldg Date signed 2/24/48

VS 150

C60505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

C60505

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1719 LANCASTER ST.

(c) Hospital or institution: - - NONE - - 2-3

(d) Length of stay in hospital or inst. (yrs., mos., or days) -

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 1719 LANCASTER ST. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country - - - -

3 (a) FULL NAME EMMA WILKINS

3 (b) If veteran, name war - - - -

3 (c) Social Security Account No. ?

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife JOHN

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr) 12-8-1882

8. AGE: Years 65 | Months 2 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business HOME

FATHER

12. Name HERMAN SHULTZ

13. Birthplace ?

MOTHER

14. Maiden Name ?

15 Birthplace ?

16 (a) Informant HARRY CODY

(b) Address 1719 LANCASTER ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-24-48 (month) (day) (year)

(c) Cemetery or crematory OAK LAWN

Location EASTERN AVE. EXT.

18 (a) Funeral director LILLY & ZEILER INC.

(b) Address 403 S. WOLFE ST.

19 (a) FEB 24 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 21, 1948 at 8:45 M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan. 1947 to Feb 21 1948 and that I last saw [illegible] alive on Feb 20 1948.

Immediate cause of death: Cerebral Apoplexy — Duration 30 days

Due to: Cerebral Arteriosclerosis — 7 yrs.

Due to: Chronic Nephritis — 6 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible] M. D.

Address 700 W. Lexington St. Date signed 2/23/48

VS 150

660506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

660506

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 920 S. BOULDIN ST.

(c) Hospital or institution: - - - NONE - - - 26-11

(d) Length of stay in hospital or inst. (yrs., mos., or days) -

(e) Length of stay in Baltimore (yrs., mos., or days) UNKNOWN

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 920 S. BOULDIN ST. (If rural give location)

(e) Citizen of foreign country? ? (Yes or No) If yes, name country ?

3 (a) **FULL NAME** BENJAMIN F. COOK

3 (b) If veteran, name war - - - -

3 (c) Social Security Account No. ?

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife ALICE

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) 3-10-1863

8. AGE: Years 84 | Months 11 | Days 15 | If less than one day ? hr. min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual Occupation FISHERMAN

11. Industry or business - - -

FATHER 12. Name HENRY COOK

13. Birthplace ?

MOTHER 14. Maiden Name EVA BENDER

15 Birthplace ?

16 (a) Informant BENHARDT BULLOCK

(b) Address 920 S. BOULDIN ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-27-48 (month) (day) (year)

(c) Cemetery or crematory SCHWARTZ

Location O'DONNELL ST.

18 (a) Funeral director LILLY & ZEILER INC.

(b) Address 403 S. WOLFE ST.

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 23, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11 1947 to Feb 23 1948, and that I last saw h[illegible] alive on Feb 22 1948.

Immediate cause of death	Duration
Arteriosclerotic C.V. Disease	12-11-47
Due to Chr. Pancreatitis	2-10-48
Due to Pneumococcal Peritonitis	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation None

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? None (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Ea Schwartz M. D.

Address 842 E. Eutaw Date signed 2-28-48

VS 159

X

660507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 660507

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2-3
(c) Hospital or institution: West Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 505 S. Washington St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Charles A. McComas.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Florence
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10-11-1909

8. AGE: Years	Months	Days	If less than one day
38	4	12	hr. — min. —

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation File setter
11. Industry or business

FATHER
12. Name Chas. F. McComas
13. Birthplace Balto

MOTHER
14. Maiden Name Wilhelminia ?
15. Birthplace Balto.

16 (a) Informant Florence McComas.
(b) Address 505 S. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-48 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location North Ave.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. Wolfe St.

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) Waiting for Williams MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-23 1948, at 3:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-23 1948, to 2-23 1948, and that I last saw h/her alive on 2-23 1948.

Immediate cause of death Coronary Occlusion — Duration —
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature W. W. Biedeman M.D.
Address W. Balto. Dr. Hosp. Date signed 2-28-48

For Dr. Wm. S. Halsted, Physician-in-Chief, Johns Hopkins Hospital

VS 150

660508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 660508

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Hebrew Home for Aged 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Greenspring Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Hausman (Housman)

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 48 | Months | Days | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Harris
13. Birthplace Russia

MOTHER
14. Maiden Name Zelzda
15. Birthplace Russia

16 (a) Informant Ethel Greene
(b) Address 1202 No Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-48 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herring Run

18 (a) Funeral director Jack Levin Inc
(b) Address 210 No. Eutaw St.

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22nd 1948, at 12 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15th 1948, to Feb 22nd 1948, and that I last saw h.. alive on Feb 22nd 1948.

Immediate cause of death	Duration
Coronary Occlusion	
Due to	
Due to	
Other Conditions Cerebral birth palsy with epileptiform seizures (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jerome J Blumberg M. D.
Address Eversdale Road Date signed 2/22/48

VS 150

660509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 660509

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2922 Harford Rd.
(c) Hospital or institution: 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2922 Harford Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosaria Scaldara SCALDARA

3 (b) If veteran, name war none

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~David~~ John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 8 ~~1886~~ 1886

8. AGE: Years	Months	Days	If less than one day
(1) 61	6	13	hr. min.

9. Birthplace Scordia Italy
(Town, county, and state)
10. Usual Occupation Housewife Home
11. Industry or business

MOTHER / FATHER
12. Name Sebastiano Modo
13. Birthplace Italy
14. Maiden Name Filomena Pilato
15. Birthplace Italy

16 (a) Informant Sebastian Scaldara (Son)
(b) Address 2922 Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 25 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.

19 FEB 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/21/48 19 at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1947 to Feb 21 1948, and that I last saw her alive on Feb 20 1948.

Immediate cause of death Arteriosclerotic hypertension and Cardio Vascular disease.
Due to
Due to
Other Conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Anthony Scaldara M.D.
Address 5217 York Rd Date signed 2/23/48

937

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G60510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G60510

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1224 McCulloh St.
(c) Hospital or institution: 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 McCulloh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME KATIE ELIZABETH RICE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1877

8. AGE: Years	Months	Days	If less than one day
70	8	11	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Law
13. Birthplace Va.

MOTHER
14. Maiden Name Martha Bundy
15. Birthplace Va.

16 (a) Informant Mrs. Xavier McDonald
(b) Address 844 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-26-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) ~~FEB 24 1948~~ (b) Huntington Williams M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 8, 1948 to Feb. 22, 1948, and that I last saw her alive on Feb. 21 1948

Immediate cause of death Coronary Thrombosis — Duration 6 week

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mrs. Xavier McDonald M. D.
Address 844 N. Carey St. Date signed 2/23/48

V S 150

G60511

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937 ✓

Registered No. G60511

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1469 Woodall St
(c) Hospital or institution: 24-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1469 Woodall St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth T. Trapp

3 (b) If veteran, name war **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Wid

6 (b) Name of husband or wife Marcellus Trapp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 23-1875

8. AGE: Years	Months	Days	If less than one day
72	9	29	hr. min.

9. Birthplace Jersey City N.J. (Town, county, and state)
10. Usual Occupation
11. Industry or business none

FATHER 12. Name Frederick Taube
FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Catherine Schneider
MOTHER 15. Birthplace Baltimore Md.

16 (a) Informant Catherine M. Flynn
(b) Address 1469 Woodall St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-26-1948 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) FEB 24 1948 (Date rec'd by Registrar) (b) Registrar Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22 1948, at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardio-respiratory failure

Due to Generalized Arteriosclerosis Arteriosclerotic heart disease

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature R. B. McFadden M.D. (Medical Examiner.)
Date signed 2-23-48

VS 151

X

C60512 - 48790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

Registered No. C60512

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospital 26 - 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Freedy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Widowed

6 (b) Name of husband or wife Elizabeth Freedy (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-11-1874

8. AGE: Years	Months	Days	If less than one day
73	7	12	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Alfred Freedy
13. Birthplace Md.

MOTHER
14. Maiden Name Virginia Elliott
15. Birthplace Md.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 27 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Frederick Ave. Balto. Md.

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave.

19 (a) Feb 24 1948 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23, 1948, at 2-30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29 1939, to 2-23 1948, and that I last saw him alive on 2-23 1948.

Immediate cause of death	Duration
Bronchogenic Carcinoma	
Metastases to liver, spleen	
Due to & pancreas.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. T. Benford M. D.
Address Balt. City Hosp. Date signed 2-24-48

VS 150

C60513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C60513

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4020 Hickory Avenue
(c) Hospital or institution: 13-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4020 Hickory Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Martha Magdaline Frederick

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4 Sex: Female
5 Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: James Alfred Frederick
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 5-1881
8. AGE: Years 66 | Months 6 | Days 18 | If less than one day hr. min.
9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John P. Sons
13. Birthplace England

MOTHER
14. Maiden Name Maggie Pittroff
15 Birthplace Maryland

16 (a) Informant James A. Frederick
(b) Address 4020 Hickory Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 25-1948 (month) (day) (year)
(c) Cemetery or crematory Manchester
Location Manchester, Carroll Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23- 1948, at 3.15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1947, to Feb 23 1948 and that I last saw her alive on Feb 23 1948.

Immediate cause of death	Duration
Acute Pulmonary Edema	1 hr.
Due to Hypertensive C V D	2.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jerome J. Schmidt M. D.
Address 3711 Falls Rd Date signed 2-27-48

VS 159

X

G60514

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

G60514
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5800 Clarks Hill
(c) Hospital or institution: 27-13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5800 Clarks Hill (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Rosie A. Morningstar

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4 Sex: Female
5 Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: John O. Morningstar
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) Nov. 25. 1890
8. AGE: Years 57 | Months 2 | Days 28 | If less than one day hr. min.
9. Birthplace Baltimore Maryland (Town, county and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name George Imhoff
13. Birthplace Maryland

MOTHER
14. Maiden Name Matilda —
15. Birthplace Maryland

16 (a) Informant John O. Morningstar
(b) Address 5800 Clarks Hill

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 26-1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23- 1948, at 6 15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948, to Feb 23 1948, and that I last saw h alive on Feb 22 1948.

Immediate cause of death
Spinal Cord Tumor — Duration 2 yrs.
Hypertensive C-V Disease — 5 yrs.
Diabetes Mellitus — 5 yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Homer L. Wareley Jr.
Address 2900 Alameda Blvd Date signed 2/24/48

VS 150

X

C60515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

Registered No. C60515

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: U.S. Marine Hospital 24.2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 542 E. Clements St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Henry Joseph Fuchs

3 (b) If veteran, name war 1917-1918 World

3 (c) Social Security Account No. 215-05-9092

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Eva B. Fuchs
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) April 9, 1893

8. AGE: Years	Months	Days	If less than one day
54	10	14	hr. min.

9. Birthplace Cincinati, Ohio (Town, county, and state)
10. Usual Occupation Carpenter Foreman
11. Industry or business Ed Byerly & Co

FATHER
12. Name August Joseph Fuchs
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Hauber
15. Birthplace Cincinnati, Ohio

16 (a) Informant Wife + Patient
(b) Address 542 E Clements St. Balto.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Feb 26 1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Balto

18 (a) Funeral director A. Eberhard Evans
(b) Address 1400 St Charles St

19 (a) Date received by registrar FEB 24 1948 Huntington Williams, M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Feb 1948 at 6:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 14 Jan. 1948 to 23 Feb. 1948 and that I last saw him alive on 23 Feb 1948

Immediate cause of death Brain tumor — Duration 7 mos.

Due to Pneumonia, bilateral type undetermined — Duration Hours.

Due to — Duration days

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: 23 Feb. 48

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Stimson
Address U.S. Marine Hosp. Date signed 23 Feb. 48 M. D.

Stimson X

Sibley

660516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 80a

Registered No. 660516

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University 23-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 Days
(e) Length of stay in Baltimore (yrs., mos., or days) About 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. City (If outside city or town limits, write RURAL and give town)
(d) Street No. 31 E. Fort Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward S. Sibley

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-14-7514

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Oline B. Sibley (nee Rainier) 6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) February 15, 1897

8. AGE: Years	Months	Days	If less than one day
51	—	7	hr. min.

9. Birthplace Middlesex County, Virginia (Town, county, and state)
10. Usual Occupation Office Clerk
11. Industry or business Consolidated Gas & Elec. Co.

FATHER
12. Name Geo. Edw. Sibley
13. Birthplace Middlesex Co., Va.

MOTHER
14. Maiden Name Virginia Tomme Hibble
15. Birthplace Rhoaster Co., Va.

16 (a) Informant Mrs. Oline B. Sibley (Wife)
(b) Address 31 E. Fort Ave., Balto. 30, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Wed. Feb. 25, 1948 (month) (day) (year)
(c) Cemetery or crematory Hammey Grove Cemetery
Location Hammey Village, Middlesex County, Virginia

18 (a) Funeral director Virginia Undertaking Co.
(b) Address 800 S. Charles St. Balto. 30, Md

19 (a) FEB 24 1948 (Date received by registrar) Huntingtown, Williamsport, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2/22/48 19 , at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/21/47 19 , to 2/22/48 , and that I last saw h alive on 2/22/48 19 .

Immediate cause of death Respiratory failure
multiple
Due to Cerebral abscess

Due to Rheumatoid Arthritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. A. Pannell Jr. M. D.
Address Univ. Hosp. Date signed 2/23/48

VS. 150

X

AKCZYNSKI

660517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 660517

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 424 S. Durham St.
(c) Hospital or institution: 2-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 424 S. Durham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Pauline Akczynski

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Frank

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 21, 1867

8. AGE: Years	Months	Days	If less than one day
80	8	2	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mrs. Rozalia Krysiak
(b) Address 424 S. Durham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Road

18 (a) Funeral director M. F. Radzikowski & Son
(b) Address 1808 Eastern Ave. Baltimore, Md.

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) Huntington Hollins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Feb. 1948, at 7:05 P. M.

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. N. Kammer Jr. M.D. Medical Examiner.
Date signed 23 Feb. 48

VS 181

X

660518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 660518

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 10-1

(a) Baltimore City, Maryland

(b) Street address 1200 Valley St.

(c) Hospital or institution: Home for the Aged Poor

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1200 Valley St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Andrew Brechin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	W.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1874

8. AGE: Years	Months	Days	If less than one day
73	3.	25	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Alexander Brechin

13. Birthplace

MOTHER 14. Maiden Name Eleanor Reitch

15. Birthplace

16 (a) Informant Lillie Lintz Home Poor

(b) Address 1200 Valley St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/25/48 (month) (day) (year)

(c) Cemetery or crematory Charlottesville, Va. Location

18 (a) Funeral director Reta Wiedefeld

(b) Address 900 E. Biddle St

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 1948, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1948, to Feb 23 1948, and that I last saw him alive on Feb 23 1948.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic Myocarditis	4 yrs
Due to	
Other Conditions Arteriosclerosis (Include pregnancy within 3 months of death)	5 yrs

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E Gill Hall M. D.

Address 1631 E. North Ave Date signed 2/24/48

VS 150

X

460519
AB-96911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 460519

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 8-5
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2019 E. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Eichelman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3- 1872

8. AGE: Years	Months	Days	If less than one day
75	8	21	hr. min.

9. Birthplace Baltimore County, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Casper Eichelman
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Elizabeth Swartz
15. Birthplace Baltimore County, Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 26 1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) Huntington Wm. [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24- 1948, at 12.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-26- 1945 to 2-24 1948 and that I last saw him alive on 2- 24- 1948.

Immediate cause of death	Duration
Cerebro-Vascular accident	
Left hemiparesis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. T. Benfordt M. D.
Address Balt. City Hosp. Date signed 2-24-48

VS 150

660520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

660520 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 409 Colvin St.
(c) Hospital or institution: 5-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 409 Colvin St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George U. Stevenson

3 (b) If veteran, name war: Spanish American | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Wid.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/16/1878

8. AGE: Years	Months	Days	If less than one day
69	7	7	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Penn. R.R.

FATHER
12. Name Wm. Stevenson
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margaret Mallon
15. Birthplace Ireland

16 (a) Informant Mrs. Wm. Stevenson
(b) Address 409 Colvin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 26 1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St

19 (a) FEB 24 1948 (Date filed by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22 1948, at 6 50 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the cause of death was:

IMMEDIATE CAUSE OF DEATH Cardio-Respiratory failure

Due to Coronary Thrombosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature R. B. McFadden M.D. Medical Examiner.
Date signed 2-22-48

VS 151

G60521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. G60521

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4.4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1063 N. Gay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Miller

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 2

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1923

8. AGE: Years	Months	Days	If less than one day
26			hr. min.

9. Birthplace Chicago Ills
(Town, county, and state)

10. Usual Occupation Copper Smith

11. Industry or business

FATHER
12. Name Steve Moller
13. Birthplace Chicago Ills.

MOTHER
14. Maiden Name
15. Birthplace Chicago Ills

16 (a) Informant Steve Moller
(b) Address 1063 N. Gay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-48 (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cem
Location A. A. County

18 (a) Funeral director Joseph Kasmakes Jr.
(b) Address 602 Washington Blvd

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 1948, at 5:55 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary Edema
acute dilatation of heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 2-23-48

VS 151

660522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 660522

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27-1
(c) Hospital or institution Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3603 Echodale Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Schmalbach Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-9192

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Amelia Maria

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) 12-7-1896

8. AGE: Years 52 | Months 2 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Printer

11. Industry or business

FATHER 12. Name Harry Schmalbach

13. Birthplace

MOTHER 14. Maiden Name Anna M. Doll

15. Birthplace

16 (a) Informant Mrs. Amelia Schmalbach

(b) Address 3603 Echodale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/48 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Baltimore

18 (a) Funeral director L. J. Kyle

(b) Address 5305 Harford Road

19 (a) FEB 24 1948 (Date the day registered) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 48

20. DATE OF DEATH 2-20 1948 at 9:45 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Cardio-Respiratory Failure

Due to Coronary Thrombosis

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....

(d) Means of injury

23. Signature H. B. McFadden M.D. Medical Examiner.

Date signed 2-20-48

VS 151

660523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 660523

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard + Madison sts
(c) Hospital or institution: Maryland Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2617 Parnell Drive PURNELL (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Eliza Grace Jones

3 (b) ~~If veteran, name war~~

3 (c) ~~Social Security Account~~ No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Milton W. Jones
6 (c) ~~If alive, give age~~ years

7. Birth date of deceased (mo., day, yr) Oct. 27-1875

8. AGE: Years	Months	Days	If less than one day
72	2 3	6 25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Tom Everett
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sophia Tyler
15. Birthplace Baltimore, Md.

16 (a) Informant John W. Zirkel
(b) Address 3604 Klemle Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave.

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1948 at 5 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-15 1948 to 2-21 1948 and that I last saw h[illegible] alive on 2-21 1948

Immediate cause of death	Duration
acute dilatation of stomach	
vomiting + dehydration	
Due to diabetes	yr.
Due to	
Other Conditions arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: —

of autopsy: 2-21-48 acute dilatation of Stomach

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene A. Patterson M. D.
Address Md. Gen. Hosp. Date signed 2-22-48

VS 150

660524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. 660524

The PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 2-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 41 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 822 S. Broadway (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME John Edward Talley

3 (b) If veteran, name war --

3 (c) Social Security Account No. 216-14-3879

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) October 13,1892

8. AGE: Years	Months	Days	If less than one day
55	4	4	hr. min.

9. Birthplace Chicago, Ill. (Town, county, and state)

10. Usual Occupation Oiler

11. Industry or business Seafarer

FATHER
12. Name John Talley
13. Birthplace Scotland

MOTHER
14. Maiden Name Edith ?
15 Birthplace Scotland

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb-24-48 (month) (day) (year)
(c) Cemetery or crematory Sparrows Presbyterian
Location Balto Md.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17 1948, at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 7 1948, to Feb. 17 1948, and that I last saw him alive on Feb. 17 1948.

	Duration
Immediate cause of death 1- Postoperative state with obstructive jaundice and splenic infarction following resection of pancreas	4 days
Due to for carcinoma of pancreas	
Due to 2- Pneumonia lobar right lower lobe	2-3 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature William H. Stimson
William H. Stimson, Surgeon M. D.
Address US Marine Hospital Date signed 2/23/48

VS 150

660525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. 660525

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1850 W. Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1850 W. Baltimore St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ida M. Welsh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Randolph L. W.
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) Dec. 3-1853.

8. AGE: Years	Months	Days	If less than one day
94	2	19	hr. min.

9. Birthplace Baltimore - Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Joseph Lowe
13. Birthplace Maryland

MOTHER
14. Maiden Name Eliza Morrison
15. Birthplace Maryland

16 (a) Informant Miss Edith M. Welsh
(b) Address 1850 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 25 Feb 48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore - Md

18 (a) Funeral director F. D. Wippert & Son
(b) Address 1324 Eutaw Pl. 17

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) Curtis for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22- 1948, at 2:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/17 19 to 2/22 1948.
and that I last saw her alive on 2/22 1948.

Immediate cause of death — Cardiac failure — Duration 2 days
Due to Auricular fibrillation — 2 days
Due to Arteriosclerosis
Other Conditions Senility
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. H. Wellington II, M. D.
Address 3926 Frederick Ave signed 2/24/48
Baltimore 29 Md

VS 130

G60526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G60526

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1124 Forrest St Dur.
(c) Hospital or institution: 10-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1124 Forrest St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Joseph Hackett

3 (b) If veteran, name war None

3 (c) Social Security Account No. 218-01-3605

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) January 23, 1876

8. AGE: Years	Months	Days	If less than one day
72	1	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Thomas Hackett
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Kelly
15. Birthplace Ireland

16 (a) Informant Delia E. Caskey
(b) Address 1124 Forest Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director George L. Schnabel
(b) Address 2101 Frederick Ave.

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/24 1948, at 12 40 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to Arteriosclerotic C.V Disease

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Gilbreath M.D.
Medical Examiner.
Date signed 2/24/48

VS 151

660527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 660527

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5-2
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 211 N. High St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Taylor

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Katie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Alexandria Va (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER 12. Name George Taylor
13. Birthplace Va

MOTHER 14. Maiden Name Lucie (Unknown)
15. Birthplace Va

16 (a) Informant Wife Eichenberger
(b) Address 304 - 310 E. Pratt Westminster

17 (a) Interred (Burial, cremation, or removal) (b) Date thereof 2/26/48 (month) (day) (year)
(c) Cemetery or crematory Glenwood
Location Westminster, Md

18 (a) Funeral director W. H. Coombs Co
(b) Address Westminster Md

19 (a) FEB 24 1948 (Date rec'd by registrar) (b) Huntington Willis Reg. No.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 1948, at 2:55 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Ryder M.D. Medical Examiner.
Date signed 2-23-48

G60528

447057

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1173

G60528
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dorchester
(c) City or town Cambridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. 213 Cedar St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward L. Clash

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Millie
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 12-24-87

8. AGE: Years	Months	Days	If less than one day
60	2	—	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Odd Jobs
11. Industry or business

FATHER
12. Name James Clash
13. Birthplace Md

MOTHER
14. Maiden Name Clara Smith
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 27/48 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Cambridge md R.F.D

18 (a) Funeral director Sears & Bateman
(b) Address Cambridge Md

FEB 25 1948 (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-24- 1948 at 2 17 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-30-1947 to 2-24 1948, and that I last saw h[illegible] alive on 2-24-1948

Immediate cause of death	Duration
Uremia	5 days
Due to Toxic nephritis	7 days
Due to Septicemia	2 days
Other Conditions Anorexia, pulmonary infarcts, subphrenic abscess	2 weeks

(Include pregnancy within 3 months of death)

Date of operation 1/10/48, 1/28/48, 2/17/48
Major findings of operation: Chronic duodenal ulcer; acute pancreatitis, subphrenic abscess
Results of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dale D. Foster M.D.
Address Johns Hopkins Hosp. Date signed 2/24/48

C60529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55c

Registered No. C60529

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ. Hosp.
(c) Hospital or institution: Maryland University Hospt.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Rural near Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No. Mt Zion Church Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carrol B. Nusbaum

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Anna Mae Nusbaum

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17. 1914

8. AGE: Years 34 | Months 4 | Days 7 | If less than one day hr. min.

9. Birthplace Carroll Co. Maryland (Town, county and state)

10. Usual Occupation farmer

11. Industry or business

FATHER
12. Name Foster L. Nusbaum
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma Jane Erb.
15. Birthplace Maryland.

16 (a) Informant Mrs. Carroll Nusbaum
(b) Address Westminster, Md. R.D. #6

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/48 (month) (day) (year)
(c) Cemetery or crematory Krider's Cemetery
Location Westminster Md. R.D.

18 (a) Funeral director J. E. Myers Jr.
(b) Address Westminster Md.

19 FEB 25 1948 (Date rec'd by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/24/48 19 , at 8:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/20/48 19 , to 2/24/48 , and that I last saw him alive on 2/24/48 19 .

Immediate cause of death Respiratory Failure — Duration

Due to Carcinoma of Thyroid

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. H. Carroll Jr. M. D.

Address Univ. Hosp. Date signed 2/24/48

VS 150

846-W-36th St.

C60530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

Registered No. C60530

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4525 Keswick Rd.
(c) Hospital or institution: 27-14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4525 Keswick Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida S. Norris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widow

6 (b) Name of husband or wife: Sgt. Jos. Norris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/13/1867

8. AGE: Years	Months	Days	If less than one day
80	11	9	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER 12. Name	Michael Francis King
13. Birthplace	Balto Md.
MOTHER 14. Maiden Name	Ida S. King
15. Birthplace	Balto. Md.

16 (a) Informant Mrs Wm. J. O'Connor
(b) Address 4525 Keswick Rd.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-25-48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto. Md.
18 (a) Funeral director Maurice Cook Sykes
(b) Address 1600 W. North Ave.
19 FEB 25 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1948, at 1:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947 to Feb 22 1948, and that I last saw her alive on Feb 20 1948.

Immediate cause of death: Cardiac decompensation — Duration 2 wks.
Due to Chronic cardio-vascular disease — 10 yrs
Due to Diabetic Mellitus — 10 yrs
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [signature] M.D.
Address 4426 Eden 36 1490. Date signed 2/24/48

VS 150

X

G60531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. G60531

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3331 Mc Elderry St

(c) Hospital or institution: 2610

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3331 Mc Elderry St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** James H Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Mamie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14 1869

8. AGE: Years 78 | Months 11 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county and state)

10. Usual Occupation Woolen Cutter

11. Industry or business

FATHER

12. Name James H Mitchell

13. Birthplace Baltimore Co Md

MOTHER

14. Maiden Name Emma J Simmons

15. Birthplace Balto Md

16 (a) Informant Lilly Simmons

(b) Address 3331 Mc Elderry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/48 (month) (day) (year)

(c) Cemetery or crematory Western

Location Balto. Md.

18 (a) Funeral director Wilson Col Fun

(b) Address 1219 E Pratt St

19 (a) DEC 25 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1948, at 2 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1948 to Feb 23 1948 and that I last saw h/m alive on Feb 20 1948.

Immediate cause of death ARTERIOSCLEROSIS — Duration 9 Yrs

Due to

Due to

Other Conditions HYPERTENSION — 9 Yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Percy F Karavaugh MD

Address 3014 Mc Elderry St Date signed 2-27-48 M. D.

VS 150

C60532

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 477

C60532 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 175 W Lanvale St
(c) Hospital or institution Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 M
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 Guilford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie L. Bell

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife Walter R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2. 1877

8. AGE: Years 70 | Months 11 | Days 21 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Sidney Short
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Forest W Bell
(b) Address 1807 Guilford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Lodge
Location Loyers Md

18 (a) Funeral director Wilkerson & Son Inc
(b) Address 1217 E Pont St

19 (a) FEB 25 1948 (Date rec'd by registrar) (b) Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1948, at 2 30 P M

21. I certify that I took charge of the remains described above, held an Aug Ed Autop. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of Lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Kelbach M.D. Medical Examiner.
Date signed Feb 25, 1948

VS 151

C60533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

C60533
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 3.2
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 840 S. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Walter Lachoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 13th 1873

8. AGE: Years	Months	Days	If less than one day: hr.	min.
75	1	9		

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Lachoff
13. Birthplace Germany

MOTHER
14. Maiden Name Henriette Lachoff
15. Birthplace Germany

16 (a) Informant Anna Harmon
(b) Address 8200 Phila Rd

17 (a) Burial (b) Date thereof 2/27/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or Crematory Cedar Hill
Location A.A. Co., Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 FEB 25 1948 (Huntington Williams M.D.)
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 1948, at 7:45 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl M. Ryan M.D.
Medical Examiner

Date signed 2-23-48

VS 151

660534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 660534

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 4-2
(b) Street address
(c) Hospital ~~or institution~~: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 526 W. Balto. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Serio

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Orsalina Serio

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 19th 1885

8. AGE: Years	Months	Days	If less than one day
62	3	34	hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Dealer

11. Industry or business Fruit

FATHER
12. Name Jack Serio
13. Birthplace Italy

MOTHER
14. Maiden Name Concetta Lamatina
15. Birthplace Italy

16 (a) Informant Orsalina Serio
(b) Address 526 W. Balto. St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/27/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) FEB 25 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Feb. 1948, at 6 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. A. Kammer Jr. M.D.
Medical Examiner.
Date signed 23 Feb. 48

X

660535 299552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1358

Registered No. 660535

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 7-3
(b) Street address
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 944 N. Duncan St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Sindt

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Duane Sindt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-4-73

8. AGE: Years	Months	Days	If less than one day
74	3	19	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation House painter
11. Industry or business

FATHER
12. Name Fred Sindt
13. Birthplace Md

MOTHER
14. Maiden Name Dorothy Bauchard
15. Birthplace Md.

16 (a) Informant Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-25-48 (month) (day) (year)
(c) Cemetery or crematory Oak Hill Cem
Location Balto Md

18 (a) Funeral director Frank Brockbon
(b) Address 900 Chester ave

19 FEB 25 1948 (Date rec'd by Registrar) Registrar for Baltimore City

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 1948 at 4 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1948 to Feb 23 1948 and that I last saw him alive on Feb 23 1948

Immediate cause of death	Duration
Uremia	4 weeks
Due to Lower Nephron nephrosis	2 weeks
Due to Benign Prostatic Hypertrophy	
Other Conditions Hypertensive Cardiovascular disease	

(Include pregnancy within 3 months of death)

Date of operation 2-17-48
Major findings of operation: Urinary obstruction
of autopsy: Uremia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Terry B. Shidemantle M. D.
Address Johns Hopkins Hosp. Date signed 2-23-48

VS 190

660536 F 18834 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 87E Registered No. 660536

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 19-1
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1729 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Frances Spence

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 5 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Herbert Bowe
13. Birthplace N.C.

MOTHER
14. Maiden Name Margret Spence
15. Birthplace N.C.

16 (a) Informant Miss Finney
(b) Address 1729 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-48 (month) (day) (year)
(c) Cemetery or crematory Location Mt. Calvary

18 (a) Funeral director A. Halstead
(b) Address 918 Reed Street Ave.

19 (a) FEB 25 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 Feb 1948, at 3:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ..... death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchio-pneumonia

Due to

Other Conditions Congenital Syphilis
Pandysentery.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earle L. Royer M.D. Medical Examiner.
Date signed 22 Feb 48

107

VS 151

C60537

BC-48-01740 / 182a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C60537

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17-1
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) One
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 553 - Orchard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Oscar Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1948

8. AGE: Years: 3 wks | Months: - | Days: 25 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Oscar Lee Brown Sr.
13. Birthplace Pa.

MOTHER
14. Maiden Name Georgiana Taylor
15. Birthplace Md.

16 (a) Informant Oscar Lee Brown Sr.
(b) Address 553 - Orchard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/25/48 (month) (day) (year)
(c) Cemetery or crematory
Location Mt Calvary

18 (a) Funeral director A. Halsted
(b) Address 918 - Druid Hill

19 FEB 25 1948 (Date rec'd by registrar) (Signature of Registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 1948, at 9 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Mechanical suffocation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-22-48 at ? 17/1 A.M.
(b) Where did injury occur? 553 Orchard St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Probably by clothes

23. Signature Medical Examiner M.D.
Date signed 2-23-48

VS 151

660538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

660538 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17-1
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 Little George St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Samuel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
34			hr. min.

9. Birthplace S. C. (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Charles Samuels
13. Birthplace S. C.

MOTHER
14. Maiden Name Sofa Davis
15. Birthplace S. C.

16 (a) Informant Corine Samuels
(b) Address 415-Little Geo, St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/48 (month) (day) (year)
(c) Cemetery or crematory Lynchburg to Cor
Location Abs. Calvert

18 (a) Funeral director A. Halstead
(b) Address 918-Lemmon, Hillsboro

19 (Date rec'd by registrar) FEB 25 1948 (Entries for Williams, M.R.) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 1948, at 3 45 PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture 3rd Dorsal Vertebrae

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-16-48 at 2 27 P M. (Hour)
(b) Where did injury occur? York Rd. & Belvedere Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? yes
(d) Means of injury Fell from building Structure

23. Signature [signature] M.D. (Medical Examiner)
Date signed 2-29-48

X

660539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 456

Registered No. 660539

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 903-Shields Place.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 903-Shields Place (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME John McNish

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex M. | 5 Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31 1860

8. AGE: Years 48 | Months - | Days 21 | If less than one day hr. min.

9. Birthplace Jamaica (Town, county and state)

10. Usual Occupation Mercht. Marine Seaman

11. Industry or business ?

FATHER 12. Name ?

13. Birthplace Jamaica

MOTHER 14. Maiden Name ?

15. Birthplace Jamaica.

16 (a) Informant Fred Holley

(b) Address 903-Shields Pl.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-25-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Holabird Ave.

18 (a) Funeral director C. Holabird

(b) Address 918-Reisterstown Rd.

19 FEB 25 1948 Date rec'd by registrar Huntington Williams M.D. Registrar

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-21- 1948 at 10:05 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to 2/21 1948 and that I last saw h[illegible] alive on 2/20 1948.

Immediate cause of death Tetanus Bacillus

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 hrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed 2/24/48

G60540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

169

Registered No. G60540

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2419 Ridgley st 2-3
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2419 Ridgley st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Kirby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1921

8. AGE: Years 27 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name James Kirby
13. Birthplace North Carolina

MOTHER
14. Maiden Name Grace Nutt
15. Birthplace Virginia

16 (a) Informant Grace Nutt Kirby
(b) Address 21 Fifth St. N.E. Wash. D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location West Port Balto. Md

18 (a) Funeral director Metropolitan Funeral Home Inc
(b) Address 927 N. Mount st.

19 (a) FEB 25 1948 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21 1948, at 8:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of cervical spine with crushed cord

Due to

Other Conditions Multiple fractures. crushed chest

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-21-48 at 7:45 25/3 P.M.
(b) Where did injury occur? B & O R.R. - Amsg. Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Pl. While at work?
(d) Means of injury Pedestrian struck by train

23. Signature [signature] M.D. Medical Examiner
Date signed 2-23-48

VS-131

X

G60541 wolf 3071

BALTIMORE CITY HEALTH DEPARTMENT ✓ G60541 Registered No.

CERTIFICATE OF DEATH #3a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1543 E. Madison St
(c) Hospital or institution: 7-5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1543 E. Madison St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Flora Boyd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years 89 | Months | Days | If less than one day hr. min.

9. Birthplace Littleton N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Tom Boyd
13. Birthplace N. C.

MOTHER 14. Maiden Name unknown
15. Birthplace " "

16 (a) Informant Mary Alston
(b) Address 1543 E. Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 27-1948 (month) (day) (year)
(c) Cemetery or crematory Oak Grove Cem
Location Littleton N. C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly ave

19 FEB 25 1948 (Date rec'd by Registrar) Huntington Williams M.D.

Feb. 23 **MEDICAL CERTIFICATION** 1:00 am

20. DATE OF DEATH Feb. 23 1948, at 8:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7 1948, to Feb. 23 1948 and that I last saw h alive on Feb. 23 1948.

Immediate cause of death Uremia — Duration 1 day
Due to Cerebral Apoplexy — 16 days
Due to Hypertension — ?
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. A. Berry M. D.
Address 1420 E. Chase Date signed Feb. 25. 48

VS 150

G60542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1318

Registered No. G60542

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3503 Reisterstown Road
(c) Hospital or institution: 15-12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3503 Reisterstown Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SArah Davis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Isaac

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Nathan Sterman
13. Birthplace Russia

MOTHER
14. Maiden Name Unkown
15. Birthplace Russia

16 (a) Informant Isaac Davis
(b) Address 3503 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb, 25, 1948 (month) (day) (year)
(c) Cemetery or crematory Sharrei Zion Cemetery
Location Hamilton Ave Rosedale

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) FEB 25 1948 (b) (Date filed by registrar)

MEDICAL CERTIFICATION 10.05

20. DATE OF DEATH February 24 1948 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1947 to Feb. 24 1948 and that I last saw h[illegible] alive on 2/24, 1948.

Immediate cause of death: Chronic nephritis — Duration: 1 yr.
Due to
Due to
Other Conditions Uremia — 2 days
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. A. Sussman
Address 1109 N. Calvert Date signed 2/24/48 (M. D.)

VS 190

48

G60543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. G60543

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15-11
(c) Hospital or institution: Cenn Home 4203 Springdale ave
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3305 Dorithan Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Lapedus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: Late Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1854

8. AGE: Years 93 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name UK
13. Birthplace Russia

MOTHER
14. Maiden Name UK
15. Birthplace Russia

16 (a) Informant Lester H. Lapedus
(b) Address 3305 Dorithan Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 25/48 (month) (day) (year)
(c) Cemetery or crematory Rural Cemetery
Location White Plains New York

18 (a) Funeral director Jos Levinson & Bros
(b) Address 1126 W. North ave

19 (Date received by local registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 1948 at 610 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1947 to Feb 24 1948 and that I last saw h— alive on Feb 24 1948

Immediate cause of death: Cardiac Insufficiency — Duration: 4 M

Due to: Arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Lapedus M. D.
Address 1261 E. Mulberry Date signed 2/25/48

V S 150

G60544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G60544

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St

(c) Hospital or institution: Sinai 27-19

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 26yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3418 Rockwood Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Jack Amernick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ethel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years 42 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Mens Furnishing

11. Industry or business

FATHER

12. Name Bernard

13. Birthplace Russia

MOTHER

14. Maiden Name Sarah

15. Birthplace Russia

16 (a) Informant Ethel Amernick

(b) Address 3418 Rockwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-25-48 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Levin Inc

(b) Address 2400 Eastern Ave

19 (a) [illegible] (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1948, at 3:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/4 1947 to 2/25 1948.

and that I last saw h[illegible] alive on 2/25 1948.

Immediate cause of death Sepsis

Due to Carcinoma of urinary bladder,

Due to post operative fecal fistula,

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2/6/47

Major findings of operation: Carcinoma of urinary bladder

of autopsy: none

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Irwin Shapiro M. D.

Address Sinai Hospital Date signed 2/25/48

VS 150

X

C60545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

(37)

Registered No. C60545

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 757 Vine St.

(c) Hospital or institution: 4-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 757 Vine St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Widower

6 (b) Name of husband or wife Thomas Moore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 12, 1869

8. AGE: Years	Months	Days	If less than one day
79	1	10	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Isaac Seldon

13. Birthplace Richmond, Virginia

MOTHER 14. Maiden Name Jane Anderson

15. Birthplace Calvert County, Md.

16 (a) Informant Mrs. Lumby

(b) Address 757 Vine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 26 1948 (Month) (day) (year)

(c) Cemetery or crematory Woodlawn Memorial

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 19 48 at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 1948 to Feb 22 19 48 and that I last saw her alive on Feb 22 19 48

Immediate cause of death	Duration
Bronchio-pneumonia	6 days
Due to	
Due to	
Other Conditions Contributing thereto	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature W. H. Watts M. D.

Address 515 N. Carlton Date signed 2/25/48

VS 150

107

1:60546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 B

✓ C60546 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 19-1
(b) Street address 309 W. Lemmon St
(c) Hospital or institution: Franklin Square Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 W. Lemmon St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRED MITCHELL
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Widow

6 (b) Name of husband or wife Susie Mitchell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1892

8. AGE: Years	Months	Days	If less than one day
56	5	13	hr. min.

9. Birthplace Charleston S.C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER	12. Name James Mitchell
	13. Birthplace Charleston S.C.
MOTHER	14. Maiden Name Diana Green
	15. Birthplace Charleston S.C.

16 (a) Informant Samuel Mitchell
(b) Address 836 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 26, 1948 (month) (day) (year)
(c) Cemetery or crematory W.M. Zion Cem.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) FEB 25 1948 (Date rec'd by registrar) (b) Interring for Williams, Mgr. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-23 1948, at 12.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-22 1948, to 2-23 1948, and that I last saw him alive on 2-23 1948.

Immediate cause of death: Intestinal obstruction
Cerchoma of liver

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Lahann M. D.
Address Franklin Sq. Hosp Date signed 2-23-48

X

G60547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G60547

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 Ellamont St
(c) Hospital or institution Fenhlatt Home 15-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1539 No Smallwood St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3. (a) FULL NAME Nathan Schindlis

3. (b) If veteran, name war | 3. (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6. (a) Single, married, widowed, or divorced: Widowed

6. (b) Name of husband or wife Sarah
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-5

8. AGE: Years 83 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Not known
13. Birthplace Russia

MOTHER
14. Maiden Name Not known
15. Birthplace Russia

16. (a) Informant Mrs Nathan Hoffman
(b) Address 1539 No Smallwood St

17. (a) Burial (b) Date thereof 2/26/48 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Rosedale
Location

18. (a) Funeral director Jack Levin Inc
(b) Address 2710 Eutaw Place

19. (a) FEB 25 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-25- 1948, at 1:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1948, to Feb 25 1948, and that I last saw him alive on Feb 24 1948

Immediate cause of death	Duration
Uremia	
Cardio - Respiratory failure	
Due to Cerebral Arteriosclerosis	
Hemiplegia arteriosclerotic	
Due to Art. C.V.H.D.	
Other Conditions B.P.H	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Willard Appenzeller M. D.
Address 2511 Reisterstown Rd Date signed 2/25/48

X

G60548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G60548

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Paris Village Cabin #3 Md
(c) Hospital or institution: St Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Washington Blvd. (If outside city or town limits, write RURAL and give town)
(d) Street No. Paris Village Cabin #3 Md (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Miriam Blake.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) 2/22/48

8. AGE: Years	Months	Days	If less than one day
[redacted]		1	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Blake
13. Birthplace Boston, Mass

MOTHER
14. Maiden Name Margaret Victor
15. Birthplace Brownville, Maine

16 (a) Informant Margaret Blake
(b) Address Paris Village Cabin #3 Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Fahey & Sons
(b) Address 1827 W North Ave

19 (a) FEB 25 1948 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/23/48 19 48 at 4:25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-23 1948 to 2-23 1948 and that I last saw h-er alive on 2-23- 1948

Immediate cause of death	Duration
(a) Cardiac failure	
Due to (b) Pneumonia	
Due to (c) toxemia	
Due to (d) severe acidosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Wesley Noble Jr M. D.
Address St Agnes Hospital Date signed 2-24

660549

BALTIMORE CITY HEALTH DEPARTMENT ✓ X

CERTIFICATE OF DEATH 110 B

Registered No. 660549

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2015 Druid Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED: Anne Arundel
(a) State Md. (b) County Baltimore
(c) City or town Glenburnie (If outside city or town limits, write RURAL and give town)
(d) Street No. Furnace Branch Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Norman William Blackwell

3 (b) If veteran, name war
3 (c) Social Security Account No. None

4 Sex: Male | 5 Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alethia Ga.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1904

8. AGE: Years 44 | Months — | Days 7 | If less than one day hr. min.

9. Birthplace Lancaster Co. Va. (Town, county, and state)

10. Usual Occupation Messenger

11. Industry or business Coal Office

BROTHER OF FATHER
12. Name John Blackwell
13. Birthplace Lancaster Co. Va.
14. Maiden Name Annie Jones
15. Birthplace Lancaster Co. Va.

16 (a) Informant Mrs. Alethia G. Blackwell
(b) Address Box 68 Glenburnie, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 24 1948 (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Glenburnie, Md.

18 (a) Funeral director Chas. L. Hallam
(b) Address 1631 Druid Hill Ave.

19 (a) (b) Lancaster Williamsburg Va

FEB 26 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-23-1948 at 10:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-7-48 to 2-23-1948 and that I last saw him alive on 2-23-1948.

Immediate cause of death: Bronchial Pneumonia — Duration 16 days
Due to Pleurisy — 16 days
Due to (non-T.B.)
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. L. Hallam M.D.
Address 1603 N. Caroline Date signed 2-24-48. M. D.

X

660550

BALTIMORE CITY HEALTH DEPARTMENT

660550 Registered No.

660550 GM. 117161 CERTIFICATE OF DEATH 467

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 17 Days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Anne Arundel
(c) City or town Crownsville State Hospital (If outside city or town limits, write RURAL and give town)
(d) Street No. Crownsville (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Rachel Crowner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widow

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1869

8. AGE: Years	Months	Days	If less than one day
56	8	14	hr. min.

9. Birthplace Churston, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Lewis Lowell

13. Birthplace Churston Md

14. Maiden Name Josephine Crispin

15. Birthplace Churston, Md.

16 (a) Informant Records Baltimore City Hosp

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-25-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.

Location Baltimore, Md.

18 (a) Funeral director Mrs. George N. Rodman

(b) Address 1631 Druid Hill Ave.

19 (a) (Date) Recd by (Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-20-1948, at 1.40A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-3-1948, to 2-20-1948, and that I last saw her alive on 2-20-1948.

Duration
36 hrs
mos
mos

Immediate cause of death Bronchopneumonia & renal failure

Due to Ca of rectum & metastases

Due to

Other Conditions malnutrition

(Include pregnancy within 3 months of death)

Date of operation 2/13/48

Major findings of operation: Ca of rectum

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gordon Craft M. D.

Address Balt City Hosp Date signed 2/21/48

660551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

660551 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3606 GARRISON BLVD.
(c) Hospital or institution: 15-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3606 GARRISON BLVD. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISE E SHEELY

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
NONE	NONE	F	W	WIDOW

6 (b) Name of husband or wife CHARLES F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 16, 1870

8. AGE: Years	Months	Days	If less than one day
78	0	7	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name JOHN H. BURMAN
13. Birthplace GERMANY

MOTHER
14. Maiden Name LOUISA LEMATE
15 Birthplace BALTIMORE, MD.

16 (a) Informant MRS. HARRY A. GILL
(b) Address 3606 GARRISON BLVD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/26/48 (month) (day) (year)
(c) Cemetery or crematory WOODLAWN
Location BALTO. CO., MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTIMORE, MD.

19 (a) FEB 25 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/23/48 —, at 8 08 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1948 to Feb 23 1948 and that I last saw h alive on 19.

Immediate cause of death	Duration
Cardio Vascular Nephritis	34 days.
Due to Bronchopneumonia.	8 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M Bauman Stookey M. D.
Address 2200 Garrison Blvd Date signed Feb 25/48

VS 150

X

660552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 660552

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2119 DENISON ST. 15
(c) Hospital or institution: CRAWFORD RETREAT
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO. (If outside city or town limits write RURAL and give town)
(d) Street No. 2309 N. ROSEDALE ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME CHARLES EDWARD ZELLERS

3 (b) If veteran, name war No

3 (c) Social Security Account No. yes

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	MARRIED

6 (b) Name of husband or wife CLARA M. ZELLERS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 3, 1878

8. AGE: Years	Months	Days	If less than one day
69	9	20	hr. min.

9. Birthplace FREDERICK, MD. (Town, county, and state)
10. Usual Occupation —
11. Industry or business ELITE LAUNDRY CO.

FATHER
12. Name CHARLES E. ZELLERS
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARY E. BAER
15 Birthplace UNKNOWN

16 (a) Informant MR. C. FRANK ZELLERS - SON
(b) Address 2821 CLIFTON AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/26/48 (month) (day) (year)
(c) Cemetery or crematory LORRAINE
Location BALTO. CO. MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTIMORE, MD.

FEB 25 1948 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/23/48 19..., at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1/48 19... to 2/23 1948.
and that I last saw him alive on 2/23 19 48.

Immediate cause of death Coronary Thrombosis

Due to Arteriosclerosis

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide at M
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] Date signed 2/24/48
Address 3033 W. NORTH AVE.

VS 150

X

60553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 60553

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3419 Mondawmin Ave
(c) Hospital or institution: — N-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3419 MONDAWMIN AVE
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Mrs Alice E Amos

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUL. 21, 1864

8. AGE: Years	Months	Days	If less than one day
83	7	3	hr. min.

9. Birthplace BALTIMORE, MD
(Town, county, and state)
10. Usual Occupation NONE
11. Industry or business —

FATHER
12. Name JAMES HENRY AMOS
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name LAURA J. WOODS
15. Birthplace BALTIMORE, MD.

16 (a) Informant MR. C. EUGENE KLEIN
(b) Address 3816 BARRINGTON RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/26/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ WESTERN
Location BALTIMORE, MD.

18 (a) Funeral director Wm. J. TICKNERS & SONS
(b) Address BALTIMORE, MD.

19 (a) FEB 25 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1948, at 7:30 A M

21. I certify that I took charge of the remains described above, held an Aug Ed Surg Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions Malnutrition

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William E Hedfield M.D.
Medical Examiner.
Date signed 2/24/48

VS 181

G60554

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

G60554 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23-2
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1603 S. CHARLES ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME HARRY D DAVIS

3 (b) If veteran, name war No

3 (c) Social Security Account No. 213-[illegible]-9853

4. Sex M

5. Color or race W

6 (a) Single, married, ~~widowed~~, or ~~divorced~~ MARRIED

6 (b) Name of husband or wife GLADYS E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 11 1884

8. AGE: Years 63 | Months 5 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation PURCHASING AGENT Retired

11. Industry or business BALto TRANSIT CO.

FATHER
12. Name CORTEZ D. DAVIS
13. Birthplace Va.

MOTHER
14. Maiden Name LIZZIE SCHEM
15. Birthplace BALto., MD

16 (a) Informant MRS. GLADY E. DAVIS
(b) Address 1603 S. CHARLES

17 (a) BURIAL (Burial, cremation, or removal) **(b) Date thereof** 2/27/48 (month) (day) (year)
(c) Cemetery or crematory WOODLAWN
Location BALto. Co., MD.

18 (a) Funeral director Wm. J. TICKER & SONS
(b) Address BALto. MD.

19 (a) FEB 25 1948 (Date rec'd by registrar) (Huntington Williams MD) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24 1948, at 7 32 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-14 1948 to 2-24 1948 and that I last saw him alive on 2-24 1948

Immediate cause of death RESPIRATORY FAILURE — Duration ...

Due to UREMIA — ...

Due to CHRONIC INTRACAP SCLLARY NEPHRITIS — ...

Other Conditions DIABETES MELLITUS — ...
(Include pregnancy within 3 months of death)

Date of operation ...

Major findings of operation: ...

of autopsy: ...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? ...
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ...
(Specify type of place)
(e) Means of injury ...

23. Signature J. L. Manow Jr. M. D.
Address Md. Gen. Hosp. **Date signed** 2-24-48

VS 150

131B

660555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. 660555

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town HALETHROPE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 PARK AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Thelma Pauline Upton

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or ~~wife~~ GILBERT R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 30, 1906

8. AGE: Years	Months	Days	If less than one day
41	10	24	hr. min.

9. Birthplace BALTO., MD
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name FREDERICK JUENGST
13. Birthplace GERMANY

MOTHER
14. Maiden Name MAMIE DENNIGER
15. Birthplace MARYLAND

16 (a) Informant MR. GILBERT R. UPTON - (HUSBAND)
(b) Address 1807 PARK AVE - HALETHROPE, MD.
17 (a) BURIAL (b) Date thereof 2/27/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON PK
Location BALTO., MD
18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address BALTIMORE, MD.
19 (a) FEB 25 1948 (b) Huntington Williams M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 Feb 1948, at 12 53 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 22 Feb 1948 to 24 Feb 1948, and that I last saw her alive on 24 Feb 1948

Immediate cause of death	Duration
Cardiac failure	
Due to Rheumatic Heart Dis Mitral Stenosis	
Due to	
Other Conditions Uremia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address A. J. Lahaim M. D.
Date signed 24 Feb 1948

VS 180

660556 JL - 117694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660556

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town ~~Baltimore~~ Millers Island (If outside city or town limits, write RURAL and give town)
(d) Street No. 12th- Millers Island (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Winfield Grim

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Della
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jul. 5, 1879

8. AGE: Years	Months	Days	If less than one day
68	5	19	hr. min.

9. Birthplace Va. - WINCHESTER (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business —

MOTHER / FATHER
12. Name Samuel N. GRIM
13. Birthplace Va.
14. Maiden Name Catherine M. SHERMAN
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/27/48 (month) (day) (year)
(c) Cemetery or crematory GREENMOUNT
Location BALTIMORE, MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTIMORE, MD.

19 Filed FEB 25 1948 (Signature of Registrar) Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24 1948, at 12.15 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 23 1948, to Feb. 24 1948, and that I last saw him alive on Feb. 24 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Autopsy? None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Robinson Jr. M.D.
Address Balto City Hosp. Date signed 2/28/48 M. D.

(60357 Brune St)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 ✓

Registered No. 60557

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 702 Brune St 173
(c) Hospital or institution: Brune St

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 702 Brune St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Tates

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Colored	Married

6 (b) Name of husband or wife Mabel Tates
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1892

8. AGE: Years	Months	Days	If less than one day
55	3	29	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Robert Tates
13. Birthplace Richmond Va.

MOTHER
14. Maiden Name Jennie Jones
15. Birthplace Frederick Md.

16 (a) Informant Mabel Tates
(b) Address 702 Brune St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 27 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 FEB 25 1948 (Date filed by registrar) (Signature of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/25 1948, at 9:25 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to Hypertension C.V. disease

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Holmes M.D.
Medical Examiner.
Date signed 2/23/48

VS 151

X

660558 JL - 92456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1313

Registered No. 660558

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 15-1
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 603 Collett St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Watson Ray

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1902

8. AGE: Years	Months	Days	If less than one day
45	9	27	hr. min.

9. Birthplace N. C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Silas Ray
13. Birthplace N. C.

MOTHER
14. Maiden Name Elma Davidson
15. Birthplace N. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) FEB 25 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 1948, at 7.05A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 7 1948 to Feb. 23 1948, and that I last saw him alive on Feb. 23 1948.

Immediate cause of death	Duration
Pulmonary tuberculosis & Cavitation	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. T. Binford M. D.
Address Balt. City Hosp. Date signed 2-24-48

BC-48-05048 ✓ 660559

660559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. 660559

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

20-6

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Streets
(c) Hospital or institution: University Maryland Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt.
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 Hurley Ave. Balt. #23
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby girl TARNTINO (Helen Irene Tarantino

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: newborn

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-21-48

8. AGE: Years | Months | Days: 3 | If less than one day: hr. min.

9. Birthplace University Md. Hospital. (Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business

FATHER 12. Name Anthony Joseph TARNTINO

13. Birthplace Long Island, N.Y.

MOTHER 14. Maiden Name Helen Alma Farley

15. Birthplace Dundalk, Pa.

16 (a) Informant Mother

(b) Address 508 Hurley Ave. Balt. #23

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 25, 1948 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Balto. Md.

18 (a) Funeral director John Bernard Sons

(b) Address Towson, Md.

19 (a) FEB 25 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-24-48 19 11:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-21 1948 to 2-24 1948 and that I last saw her alive on 2-24 1948

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Congenital Heart Disease (Type undetermined)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. C. Covey, Jr. M. D.

Address University Md. Hosp. Date signed 2-24-48

VS 150

X -

660560 AB-113961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

660560 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: John W. Schweiger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Josephine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 14- 1903

8. AGE: Years 44 | Months 6 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Schweiger-(D
13. Birthplace Maryland

MOTHER
14. Maiden Name Johanna Murphy-(D
15. Birthplace Maryland

16 (a) Informant Records-Baltimore C ity Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 28 48 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donell St.

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S Wolfe St.

19 (a) Washington Williams, M.D. Registrar

FEB 28 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23- 1948, at 6.05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-20- 1947 to 2-23 1948, and that I last saw h imalive on 2-23- 1948.

Immediate cause of death: Pulmonary tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. T. Benford M. D.
Address Balt. City Hosp. Date signed 2-24-48

X

C60561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

84a

Registered No. C60561

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6202 PLANTVIEW WAY

(c) Hospital or institution: — — NONE — 26-6

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 6202 PLANTVIEW WAY (If rural give location)

(e) Citizen of foreign country? — No — (Yes or No)

If yes, name country — — — — —

3 (a) FULL NAME GERALD WILLARD SHAWVER JR.

3 (b) If veteran, name war: NONE

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	SINGLE

6 (b) Name of husband or wife — NONE —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) 4-12-1940

8. AGE: Years	Months	Days	If less than one day
7	10	12	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation — NONE — —

11. Industry or business — NONE — —

FATHER

12. Name GERALD W. SHAWVER

13. Birthplace MD.

MOTHER

14. Maiden Name LEOLIA BEVERIDGE

15. Birthplace MD.

16 (a) Informant GERALD SHAWVER-FATHER

(b) Address 6202 PLANTVIEW WAY

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-27-48 (month) (day) (year)

(c) Cemetery or crematory LOUDEN PARK

Location FREDRICK AVENUE

18 (a) Funeral director LILLY & ZEILER INC.

(b) Address 403 S. WOLFE ST.

19 (a) 2-25-1948 (Date received by registrar) (b) Huntington for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 24, 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1946 to Feb 24 1948, and that I last saw him alive on Feb 24 1948

Immediate cause of death: Congenital Idiocy — Duration: 6 yrs

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Howard Burns M. D.

Address 59 Dundalk Ave Date signed

VS 150

X

660562

AB-117664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. 660562

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1hr. 15min
(e) Length of stay in Baltimore (yrs., mos., or days) 12yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk (Rural)
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rt-3-Box 282- Dundalk, Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred Quarells, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-20-8529

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8-1907

8. AGE: Years	Months	Days	If less than one day
41	1	21	hr. min.

9. Birthplace Virginia - Essex Co.
(Town, county, and state)

10. Usual Occupation City Dump--Self

11. Industry or business

FATHER
12. Name Fred Quarells
13. Birthplace Virginia

MOTHER
14. Maiden Name Frances Muse
15. Birthplace Virginia

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 2-26-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Balto., Md.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.

19 (a) FEB 25 1948 (b) Lutherville, Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22- 1948, at 7.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-22- 1948, to 2-22- 1948, and that I last saw him alive on 2-22- 1948.

Immediate cause of death Pulmonary Edema — Duration 7

Due to Cor Pulmonale — 7

Due to Emphysema Pulmonary — 7

Other Conditions Bronchopneumonia — weeks

Lobar, organism undet.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp Date signed 2-24-48

VS 150

95c

C60563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. C60563

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 824 S. Bond St.
(c) Hospital or institution: 32
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 824 S. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Zielinski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anselia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

MOTHER / FATHER

12. Name —

13. Birthplace Poland

14. Maiden Name —

15. Birthplace Poland

16 (a) Informant Emilia Zielinski

(b) Address 824 S. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-48 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Balto., Co.

18 (a) Funeral director Wm. J. Fialkowski

(b) Address 2007 Eastern ave

19 (a) (Date rec'd by registrar) Signature of Registrar William

FEB 25 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24 1948, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 17, 1948 to Feb. 24 1948 and that I last saw h— alive on Feb. 24 1948.

Immediate cause of death: Acute Broncho-pneumonia — Duration 1 wk

Due to Primary

Due to

Other Conditions Chr. Myocarditis

Carcinoma Rectum (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul J. Dennigan M. D.

Address 2007 E. Fait Ave Date signed 2/27/48

107

G60564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G60564 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5608 York Road
(c) Hospital or institution: 27-17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5608 York Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma L. Koetlee

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) ~~Single~~, ~~married~~, widowed, or ~~divorced~~
Female	White	Widow

6 (b) Name of ~~husband~~ or wife Late Henry L.
6 (c) If alive, give age, years

7. Birth date of deceased (mo., day, yr) July 16 1855

8. AGE: Years	Months	Days	If less than one day
92	7	7	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business at Home

FATHER
12. Name Henry L. Koetlee
13. Birthplace Baltimore

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. George E. Bartlett
(b) Address 3959 Cloverhill Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 26 1948 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Road

18 (a) Funeral director John A. Moran
(b) Address 3 [illegible]

FEB 25 1948 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1948 at 1 53 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 29 1946 to Feb 23 1948, and that I last saw ~~him~~ her alive on Feb 21 1948.

Immediate cause of death	Duration
Senility	2 yrs.
Due to	
Due to	
Other Conditions Carcinoma of breast	2 yrs.

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Shaffer M. D.
Address 6210 York Rd (Date signed Feb 24 1948)

VS 150

162 B

G60565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. X✓G60565

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2234 Tacoma St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) LAST about 3 wks.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (28) (If outside city or town limits, write RURAL and give town)
(d) Street No. 35 Nunnery Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country —

3 (a) FULL NAME John Nagel

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Minnie Nagel (Nee Hinkle) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1865

8. AGE: Years	Months	Days	If less than one day
82	2	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at Home
11. Industry or business —

FATHER
12. Name Lawrence Nagel
13. Birthplace Germany

MOTHER
14. Maiden Name Kunagunda (Nee ?)
15. Birthplace Germany

16 (a) Informant Lawrence J. Nagel (Son)
(b) Address 35 Nunnery Lane, Catonsville 28, Md.

17 (a) Burial — (b) Date thereof Fri. Feb. 27, 1948 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cemetery
Location Anne Arundel Co. Md.

18 (a) Funeral director A. Howard Evans
(b) Address 1400 S. Charles St., Balto. 30, Md.

19 (a) FEB 25 1948 (b) Huntington, Williamsport, Md. (Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Tues., Feb. 24, 1948, at 10:15 P. M.
21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1948, to Feb 24 1948, and that I last saw him alive on Feb. 24 1948.

Immediate cause of death Arteriosclerotic Cardiovascular Disease — Duration
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature C. Luther Kaufberg M.D.
Address 2411 Wash. Blvd. Date signed 2/25/48 M. D.

X

C60566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C60566 ✓ 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 134 W. Clement St.
(c) Hospital or institution: 23-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 W. Ostend St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John T. Hill

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower —

6 (b) Name of husband or wife Sophie Hill (nee Dehn)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1868

8. AGE: Years	Months	Days	If less than one day
80	—	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation At Home —

11. Industry or business —

FATHER
12. Name Edwin C. Hill
13. Birthplace Md.

MOTHER
14. Maiden Name Lydia A. Bigdon
15. Birthplace Md.

16 (a) Informant Raymond J. Hill (Son)
(b) Address 1340 S. Hanover St. (Balto 30, Md.)

17 (a) Burial — (Burial, cremation, or removal) (b) Date thereof Feb 28, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Cem.
Location Baltimore, Md.

18 (a) Funeral director Howard Evans
(b) Address 1400 S. Charles St.

19 (a) (b)
(Signature) Evelyn Williams Registrar

VS · 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Tues., Feb 24, 1948, at 9:50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1948 to Feb 24 1948, and that I last saw him alive on Feb 24 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 hrs
Due to Arterial Hypertension	1 yr.
Due to Arteriosclerosis	1 yr.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. M. Miller M.D.
M. D.
Address 1279 Fulham Date signed 2/26/48

C60567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

C60567

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene Sts

(c) Hospital or institution University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 801 E Johnson St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Elsie Kleylein

3 (b) If veteran, name war

3 (c) Social Security Account No. W1

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	White	Widowed

6 (b) Name of husband or wife JOHN KLEYLEIN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 21 - 1877

8. AGE: Years	Months	Days	If less than one day
70	4	2	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER

12. Name not Known

13. Birthplace Germany

MOTHER

14. Maiden Name not Known

15. Birthplace Germany

16 (a) Informant Frederick Kleylein

(b) Address 429 N Clinton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/48 (month) (day) (year)

(c) Cemetery or crematory Schwartz

Location O'Donnell St

18 (a) Funeral director Claude F Hoffmann

(b) Address 163 E Broadway Huntington Station, Md

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 25 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 1948, at 8:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1948, to Feb 23 1948, and that I last saw h[illegible] alive on Feb 23 1948.

Immediate cause of death	Duration
(a) Thrombosis ? embolus	
Due to (b) Arteriosclerosis	
Due to (c) Nephritis	
Due to	
Other Conditions Intracerebral hemorrhage, Left, Hypertension and Cardiovascular disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible] M. D.

Address Univ Hosp Date signed 2/24/48

100 B

4 660568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

133a

Registered No. G60568

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 13-7

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 308 W. 37th St. 808 (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Paul J. Noel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Agnes M.

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) 1-2-80

8. AGE: Years	Months	Days	If less than one day
63	1	22	hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business B & O R. R.

FATHER 12. Name "

13. Birthplace "

MOTHER 14. Maiden Name "

15. Birthplace "

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 27, 1948 (month) (day) (year)

(c) Cemetery or crematory St. Mary's

Location Govans

18 (a) Funeral director Abercrombie Funeral Home

(b) Address 865-0 Baltimore Ave.

19 FEB 25 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-24- 1948, at 9 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-13 1948 to 2-24 1948, and that I last saw h[illegible] alive on 2-24 1948

Immediate cause of death Uremia — Duration 2 hrs.

Due to Pyelonephritis

Due to

Other Conditions Bladder neck obstruction

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Uremic Changes

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Terry D. Sudsworth M. D.

Address Johns Hopkins Hosp. Date signed 2/24/48

G60569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

777

G60569 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) One
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 625 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond R. Baker
3 (b) If veteran, name war
3 (c) Social Security Account No. 219-01-0072

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mildred M.
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Feb. 28 1905

8. AGE: Years	Months	Days	If less than one day
42	11	22	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Howard Baker
13. Birthplace Md.

MOTHER 14. Maiden Name Blanche La Vell
15. Birthplace Va.

16 (a) Informant Mildred M. Baker
(b) Address 625 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 26, 1940 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden

18 (a) Funeral director H. Reynolds Funeral Home
(b) Address 1607-17 Chestnut Ave.

19 (a) FEB 25 1940 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 1940, at 6:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Exposure

Due to

Other Conditions Chronic alcoholism

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Edward Royston M.D. Medical Examiner
Date signed 2-23-40

G60570

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G60570 Registered No. 1258

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood 81
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3417 Harford Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas L. Pearce, Sr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ella Pearce

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14 (1879) 1878

8. AGE: Years 69 (68) | Months 5 | Days 10 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county and state)

10. Usual Occupation Retired Policeman

11. Industry or business

FATHER
12. Name John Edward Pearce
13. Birthplace Balto Co. Md

MOTHER
14. Maiden Name Catherine Ann Hartsuerter
15. Birthplace Balto

16 (a) Informant Mrs. Ella Pearce
(b) Address 3417 Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/48 (month) (day) (year)

(c) Cemetery or crematory Lakewood
Location Balto

18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Rd.

19 (a) 2/25 1948 (Date rec'd by registrar) Temporary for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/24/1948, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/3/1948 to 2/24/1948 and that I last saw him alive on 2/24/1948

Duration

Immediate cause of death Aspiration of vomitus
Due to Hypotension
Due to
Other Conditions Uremia - arteriosclerosis, arteriosclerosis, generalized
(Include pregnancy within 3 months of death)
Date of operation 2/19/48
Major findings of operation: Hypotension, Gastrectomy
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James Hutchison
Address University Hospital M. D.
Date signed 2/24/48

VS 153

Dr. Stevens 660571
Harford & Hugo

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

660571 ✓
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2857 Chesterfield Ave.
(c) Hospital or institution: 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2857 Chesterfield Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Francis Lanahan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Oriole E. Lanahan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 18, 1888

8. AGE: Years	Months	Days	If less than one day
59	2	5	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Boiler Maker
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name John A. Lanahan
13. Birthplace ?

MOTHER
14. Maiden Name Eva Senft
15. Birthplace ?

16 (a) Informant Mrs. Oriole E. Lanahan
(b) Address 2857 Chesterfield Avenue

17 (a) Bruail (Burial, cremation, or removal) (b) Date thereof 2-26-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14 ar

FEB 25 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1947 to Feb 23 1948.
and that I last saw him alive on Feb. 23 1948.

Immediate cause of death
Pulmonary tbc.

Duration 7 t

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. B. Stevens M.D.
Address 3400 Erdman Ave Date signed 2/24/48

VS 193

G60572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G60572 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: ~~Jenkins Memo~~ 25:1
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave
(c) Hospital or institution:
Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7½ yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~Same~~ Jenkins Memorial Hospital
(If rural give location)
(e) Citizen of foreign country? N.R (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Pauline Schuck

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mr James Schuck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19 1879

8. AGE: Years 68 | Months 10 | Days 24 | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Joseph Moles (ZACZEK)
13. Birthplace Poland

MOTHER
14. Maiden Name Appoling Moles (Tomaszkiewicz)
15. Birthplace Poland

16 (a) Informant Hospital Record.
(b) Address Jenkins Memorial Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 Feb 25 1948 (Date rec'd by registrar) (b) Huntington Williamsport

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-24 1948 at 6 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 to Feb 1948 and that I last saw h CR alive on Feb 23 1948

Immediate cause of death Cardiac Failure — Duration

Due to Arteriosclerotic cardio-vascular

Due to disease

Other Conditions Rheumatoid arthritis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. J. Venable Jr
Address St Agnes Hospital Date signed 2-24-48 M. D.

660573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

660573 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution University Hosp'l
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town HALETHORPE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5556 LINK AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** George A. Allen

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-1176

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Married

6 (b) Name of ~~husband or~~ wife GRACE E (WILDER)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) AUG. 13, 1892

8. AGE: Years	Months	Days	If less than one day
55	6	12 11	hr. min.

9. Birthplace BALTO. MD
(Town, county, and state)

10. Usual Occupation MECHANIC

11. Industry or business ARMOUR & Co

FATHER
12. Name UNKNOWN
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant MRS GRACE E ALLEN
(b) Address 5556 LINK AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB 28 1948 (month) (day) (year)
(c) Cemetery or crematory BALTO. NATIONAL
Location 5501 FREDERICK RD

18 (a) Funeral director Henry H Wiltse
(b) Address 410 Edmondson Ave

FEB 25 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1948, at 8:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1948 to Feb 24 1948 and that I last saw h[illegible] alive on Feb 24 1948.

Immediate cause of death	Duration
Coronary occlusion	
Due to Coronary artery	
Due to Arteriosclerosis	
Due to	
Other Conditions Cirrhosis Cachexia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 2/29/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

TODD

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

660574 Registered No. 660574

660574

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Lunch Home Dept. N.S.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs 7 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 90 yrs 90 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Lunch Home Dept.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Laura Phelps Todd.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 30 1857

8. AGE: Years 90 | Months 3 | Days 26 | If less than one day hr. min. 25

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Actress, teacher

11. Industry or business Retired

MOTHER / FATHER

12. Name Jesse D. Phelps.

13. Birthplace Rhode Island

14. Maiden Name Indiana Lindsey.

15. Birthplace Centerville Md

16 (a) Informant Laurence T. Ogle

(b) Address 3701 Sequoia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 26 48 (month) (day) (year)

(c) Cemetery or crematory Green Mount

Location North & Greenmount Aves

18 (a) Funeral director John O. Mitchell & Sons

(b) Address Huntington Williams, Inc.

19 (a) FEB 25 1948 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1948, at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946, to July 24 1948, and that I last saw her alive on July 23 1948.

Immediate cause of death Cardiac insufficiency — Duration 1 yr.

Due to Arteriosclerotic heart disease. — 20 yrs.

Due to —

Other Conditions Arteriosclerosis general — 20 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isaac J. Backenstose M. D.

Address Lunch Home + Hosp. Date signed July 24 48

VS 153

X

G60575

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93

G60575
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3409 Greenway - De Soto Apts.
(c) Hospital or institution:
none 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3409 Greenway
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen West Page

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1866

8. AGE: Years 81 | Months 11 | Days 21 | If less than one day: hr. min.

9. Birthplace Frederick County, Maryland
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John W. Page
13. Birthplace Va.

MOTHER
14. Maiden Name Alan West
15. Birthplace Md.

16 (a) Informant Mrs. H. R. Latimer
(b) Address 3409 Greenway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/48 (month) (day) (year)
(c) Cemetery ~~Cemetery~~ St. Thomas'
Location Garrison Forest, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Tunstall Williams M.D. Registrar

FEB 25 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 30 Aug. 1944 to 24 Feb. 1948 and that I last saw her alive on 11 Feb. 1948

Immediate cause of death: Myocardial Insufficiency — Duration: 2 mos.
Due to: Hypertensive Cardio-vascular
Due to: Disease

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carroll Lockard, M.D.
Address 2925 N. Charles St. Date signed 24 Feb 48

Informant X

G60576

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 47D

G60576 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT ST.
(c) Hospital or institution: MERCY 27-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 MO.
(e) Length of stay in Baltimore (yrs., mos., or days) 35 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 SHERIDAN AVE (If rural give location)
(e) Citizen of foreign country? ND (Yes or No)
If yes, name country

3 (a) FULL NAME PERRY SNYDER

3 (b) If veteran, name war	3 (c) Social Security Account No. 213-16-5705

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 4, 1886

8. AGE Years	Months	Days	If less than one day
62	10	20	hr. min.

9. Birthplace W. VA. (Town, county, and state)
10. Usual Occupation CROWN CORK & STEELE
11. Industry or business

FATHER
12. Name DANIEL U. SNYDER
13. Birthplace W.VA.

MOTHER
14. Maiden Name HARRIET A. ATHEY
15. Birthplace W.VA.

16 (a) Informant ADM. SLIP.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 27-'48 (month) (day) (year)
(c) Cemetery or crematory Edgehill
Location Charlestown, W.Va.

18 (a) Funeral director Thos. F. Connelly
(b) Address 718 Eastern Ave., Balto.

19 (c) FEB 25 1948 Date rec'd by registrar Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB 24 1948 at 1:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from DEC 27 1947 to FEB 24 1948 and that I last saw h. M alive on 2/24 1948.

Immediate cause of death CARDIO-RESPIRATORY FAILURE — Duration

Due to CARCINOMA OF LUNG & METASTASIS

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: CA OF LUNG & METASTASES

PHYSICIAN Underline the cause to which death should be charged statis-

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elden H. Pratt, M.D.
Address Mercy Hosp. Date signed 2/24/48

G60577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1228

G60577 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Raynor Ave & Dukeland St. 16-6

(c) Hospital or institution: West Baltimore Genr'l

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town 1025 Poplar Grove St (If outside city or town limits, write RURAL and give town)

(d) Street No. Baltimore, MD (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country —

3 (a) **FULL NAME** MARY SCHEUCH

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: No

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: JOHN SCHEUCH

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): AUG 28, 1871

8. AGE: Years: 76 Months: 5 Days: 26 If less than one day: hr. min.

9. Birthplace: Balto., MD. (Town, county, and state)

10. Usual Occupation: HOUSEWIFE

11. Industry or business

FATHER 12. Name: JOHN BLOECHER

13. Birthplace: GERMANY

MOTHER 14. Maiden Name: MARY ?

15. Birthplace: GERMANY

16 (a) Informant: MR. JOHN C. SCHEUCH JR. (Son)

(b) Address: 2757 WINCHESTER ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/27/48 (month) (day) (year)

(c) Cemetery or crematory: WESTERN

Location: Balto, MD.

18 (a) Funeral director: Wm. J. Tichner & Sons

(b) Address: Baltimore, MD

FEB 25 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/24 1948, at 9:35 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/23 1948 to 2/24 1948 and that I last saw h[illegible] alive on 2/24 1948.

Immediate cause of death: Fractured Femur

Due to: Cause Unknown

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: Norman Levin M. D.

Address WBGH Date signed 2/24/48

VS 150

G60578

A60937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. G60578

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Parole, (If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D. - 1 - (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/22/48

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Harry Bailey

13. Birthplace Pa.

MOTHER 14. Maiden Name Grace Herring

15. Birthplace Pa.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 2-26-48 (month) (day) (year)

(c) Cemetery or crematory St. Mary's

Location Annapolis

18 (a) Funeral director A.E. Hopkins & Son

(b) Address Annapolis, Md.

19 (a) [illegible] (Date) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. - 24 - 1948 at 4 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-23-1948 to 2-24-1948 and that I last saw him alive on 2-24-1948

Immediate cause of death	Duration
Asphyxia due to Acute Atelectasis Pulmonary & Pericarditis	2 d.
Due to Congenital Malformation	
Due to	
Other Conditions Not Stated (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.

Address [illegible] Date signed 2-26-48

G60579 3C-48-00 Apr

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G60579 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 528 N. Bond Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Crank

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-13-48

8. AGE: Years | Months | Days | If less than one day: 1 hr. 30 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Albert D. Crank
13. Birthplace Chester, South Carolina

MOTHER 14. Maiden Name Willie E. Crank
15. Birthplace Chester, South Carolina

16 (a) Informant Mrs. Willie E. Crank
(b) Address 528 N. Bond Street

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School JAN 27 1948
Location

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) 1/30/48 (Date rec'd by registrar) (b) Burial permit issued by Williamsport, Md. (Registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13, 1948, at 5 20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Prematurity

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Medical Examiner. M.D.
Date signed 2-25-48

C60580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓117a

Registered No. C60580

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 W Franklin St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Frantz Weigand

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Myrtle C
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15 1890

8. AGE: Years 57 | Months 10 | Days 10 | If less than one day: hr. min.

9. Birthplace Thurmont Md (Town, county, and state)
10. Usual Occupation Inspector
11. Industry or business City

FATHER
12. Name Edward A Weigand
13. Birthplace Thurmont Md

MOTHER
14. Maiden Name Mollie Keefer
15. Birthplace Thurmont Md

16 (a) Informant Myrtle C Weigand
(b) Address 507 W Franklin St

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof 2/26/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md

18 (a) Funeral director Fulton Coffey Inc
(b) Address 1417 Eutaw Pl

19 (a) FEB 26 1948 (Date rec'd by registrar) (b) Huntington Nitkin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 1948, at 4 30p M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 Feb 1948 to 25 Feb 1948, and that I last saw him alive on 25 Feb 1948.

Immediate cause of death	Duration
Cerebral metastasis	
Due to Bronchogenic carcinoma with metastasis	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation None Biopsy 23 Jan 48
Major findings of operation: Carcinoma
of autopsy: Bronchogenic carcinoma with metastasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J B Barney M.D.
Address Univ Hosp Date signed 25 Feb 48

VS 150

C60581

RANDLES

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C60581

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3124 Foster Ave
(c) Hospital or institution:
1-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 3124 Foster Baltimore
2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3124 FOSTER Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Randles

3 (b) If veteran, name war
3 (c) Social Security Account No. 212-09-2964

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1876

8. AGE: Years 71 | Months 7 | Days - | If less than one day hr. min.

9. Birthplace Trenton N J
(Town, county, and state)

10. Usual Occupation Laborer Retired

11. Industry or business

FATHER
12. Name Samuel Randles
13. Birthplace England

MOTHER
14. Maiden Name Harriett [illegible]
15. Birthplace South Amboy N J

16 (a) Informant Frederick Randles
(b) Address 346 Foster Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/48 (month) (day) (year)
(c) Cemetery or crematory Schmans
Location Baltimore Md

18 (a) Funeral director Tillman & Jones
(b) Address 1219 E Fort Ave

19 FEB 26 1948 (Date rec'd by registrar) (Signature) Huntington Nolan M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1948, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10- 1947 to 2-25- 1948 and that I last saw h[illegible] alive on 2-24-48.

	Duration
Immediate cause of death: Arteriosclerotic C.V. Disease	
Myocardial Failure	12-10-47
Due to: Complete Coronary Occlusion	2-25-48
Due to	
Other Conditions: None	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eisahimmel M. D.
Address 842 E. East Ave Date signed 2-25-48

VS 180

X

Grave No 50-1948

660582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 660582

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 762 W Fayette (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Scott, Grace

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
F	W	Married

6 (b) Name of husband Willis Scott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Westminster Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Elizabeth Waddell
(b) Address 2409 W. Lexington St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/27/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ City Burying Grounds
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 S. Paul st

19 (a) FEB 26 1948 (Date rec'd by registrar) (b) Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22 19 48 at 12:32 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-21- 1948 to 2-22 1948, and that I last saw her alive on 2-22- 1948.

Immediate cause of death Cardiac Failure
Generalized Arteriosclerosis
Arteriosclerotic heart disease

Due to

Due to

Other Conditions Diabetes Mellitus, treated coma. Acidosis
Chronic Bronchitis. Bronchiectasis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. L. Jamison M.D.
Address University Hosp. Balto. Date signed 2-22-48 M. D.

VS 150

937

G60583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G60583

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 3703 N. Charles St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3703 N. Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lula Pearl Page

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband or wife: Joseph C. Page

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan 15th 1885

8. AGE: Years 63 | Months 1 | Days 8 | If less than one day: hr. min.

9. Birthplace: Connellsville Pa.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

MOTHER / FATHER

12. Name: John Younkin

13. Birthplace: Connellsville Pa.

14. Maiden Name: Nancy Newcomer

15. Birthplace: Connellsville Pa.

16 (a) Informant: Thos. R. Evans

(b) Address: Stratfield, Bridgeport, Conn

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/26/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~: Woodlawn

Location: " Md.

18 (a) Funeral director: William Cook Inc

(b) Address: 1217 St. Paul St

19 (a) FEB 26 1948 (Date rec'd by registrar) (b) Thurlington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 23rd 1948, at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22, 1948 to Feb 23, 1948 and that I last saw h alive on 19

Immediate cause of death	Duration
Coronary Occlusion	1 week
Due to Arterio-Sclerosis & Hypertension	yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Felix L. Greer Jr. M.D.

Address: Towson-Md Date signed 2/25/48

VS 150

X

660584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 131a

Registered No. 660584

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4104 Southern Ave.
(c) Hospital or institution:
27 - 1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4104 Southern Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHRISTINA PHILIPPI KRAUSE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife J. George Krause
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16th, 1873

8. AGE: Years	Months	Days	If less than one day
74	5	9	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Nicholas Philippi
13. Birthplace germany

MOTHER
14. Maiden Name Christina Sinsz
15. Birthplace Germany

16 (a) Informant Mr. J.G. Krause
(b) Address 4104 Southern Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 2/28/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Lasselle Funeral Home
(b) Address 7401 Belair Road

19 (a) FEB 26 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1948, at 8 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 5 1948 to Feb 25 1948. and that I last saw h alive on Feb 25 1948

Immediate cause of death	Duration
Cerebral Thrombosis	10 days
Due to Arterio-Sclerotic Hypertensive Cardio-Renal Disease	15 yrs.
Due to	
Other Conditions (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Dudler M. D.
Address 170 1/2 E Fayette St Date signed 2/26/48

VS 150

G60585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G60585

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1515 East Fairmount Ave
(c) Hospital or institution:
6-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 East Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sadie Pollack

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Max

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 53 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name not known
13. Birthplace Russia

MOTHER
14. Maiden Name not known
15. Birthplace Russia

16 (a) Informant Max Pollack
(b) Address 1516 Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-26-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philg Rd + Hamilton Ave

18 (a) Funeral director Jack Lentz Inc
(b) Address 2100 Eutaw Place

19 (a) FEB 26 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-26- 1948, at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19..., and that I last saw h... alive on ... 19...

Immediate cause of death: Coronary Thrombosis — Duration: 12 Hrs

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alvin A Hartz M. D.
Address 5443 Park Heights Ave Date signed 2/26/48

VS 150

X

THESE ITEMS, WITH EXPLANATORY NOTES, ARE IMPORTANT. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

660586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 307

Registered No. 660586

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 637 Eager Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pedro E. Rodriguez

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Puerto Rican	married

6 (b) Name of husband or wife Julia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1902

8. AGE: Years	Months	Days	If less than one day
46	1	20	hr. min.

9. Birthplace Puerto Rico (Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business

FATHER
12. Name Ygnacio Rodriguez
13. Birthplace Puerto Rico

MOTHER
14. Maiden Name Jeannette ?
15. Birthplace Puerto Rico

16 (a) Informant Urmain Berry
(b) Address 315 N. Pine Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Rd.

18 (a) Funeral director A. Halstead
(b) Address 918 - Lemmon Hill Ave

19 FEB 26 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 1948 at 12 P M

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured aneurysm of thoracic aorta & cardiac tamponade

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl K. Long M.D. Medical Examiner.

Date signed 2-24-48

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

660587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. 660587

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Baltimore Md
(a) Baltimore City, Maryland
(b) Street address [redacted] 1108 Carson ct
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 Carson Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clifton Eugene Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Chauffer.

11. Industry or business

FATHER
12. Name Wm. Dorsey
13. Birthplace unknown.

MOTHER
14. Maiden Name Julia Williams
15. Birthplace

16 (a) Informant Anna Britan.
(b) Address 822 Woodyear St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn cem
Location West Pont Balto Md

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 927. N. Mount St

19 (a) FEB 26 1948 (Date rec'd by registrar) (b) Registrar for Baltimore, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1948, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D. Medical Examiner.
Date signed 2-25-48

G60588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G60588

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1525 PENTRIDGE RD.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-9

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 1525 PENTRIDGE RD. (If rural give location)

(e) Citizen of foreign country? — (Yes or No) If yes, name country

3 (a) **FULL NAME** CATHERINE ANN REBECCA HARRIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	WIDOW

6 (b) Name of husband or wife JOHN HARRIS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 31, 1848

8. AGE: Years	Months	Days	If less than one day
99	3	23 24	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER 12. Name GEORGE WIEGAND

13. Birthplace BALTIMORE, MD.

MOTHER 14. Maiden Name UNKNOWN

15 Birthplace UNKNOWN

16 (a) Informant MR. E. A. GHANON

(b) Address 1410 KINGSWAY RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/27/48 (month) (day) (year)

(c) Cemetery or crematory GREENMOUNT MAUSOLEUM

Location BALTIMORE, MD.

18 (a) Funeral director WM. T. TURNER & SONS

(b) Address BALTIMORE, MD.

19 FEB 26 1948 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. **DATE OF DEATH** FEB 24 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15: 1948 to Feb 24. 1948, and that I last saw alive on Feb. 24. 1948.

Immediate cause of death Chronic Myocarditis — **Duration** years or More

Due to Old Age.

Due to Senility.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Stanley C. Blake

Address Med Arts Bldg Date signed 2-25-48 M.D.

X

C60589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33B

Registered No. C60589

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3400 Lyndale Avenue
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3400 Lyndale Avenue (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JULIA DEUTSCH ✓

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	SINGLE

6 (b) Name of husband or wife: —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/16/1864

8. AGE: Years	Months	Days	If less than one day
84	0	9	hr. min.

9. Birthplace WHITE MARSH, MD. (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business —

FATHER
12. Name FRANCIS DEUTSCH
13. Birthplace GERMANY

MOTHER
14. Maiden Name ANN E. BOWEN
15. Birthplace GERMANY

16 (a) Informant GILBERT CASSARD (FRIEND)
(b) Address 420 N. EUTAW ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/27/48 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location BALTIMORE, MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTIMORE, MD.

19 (a) FEB 26 1948 (Date rec'd by registrar) (b) Burial Permit Issued

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/25/1948 at 10:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/19/1948 to 2/25/1948, and that I last saw her alive on 2/25/1948.

Immediate cause of death: Heart failure — Duration: 2 weeks
Due to: old age
Due to: Influenza
Other Conditions: —
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice T. Abel M.D.
Address 1431 W. Kenhall Ave Date signed 2/28/48

V S 150

660590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 660590

PLEASE WRITE PLAINLY, with UNFADING INK. Every item or information should be obtained. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Western Electric Co 18-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 837 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph J. Lubbehusen

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Marie H. Jocaitis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18th 1900

8. AGE: Years	Months	Days	If less than one day
47	6	7	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Western Electric Co.

FATHER
12. Name Joseph Lubbehusen
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Louisa Cooper
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Marie H. Lubbehusen
(b) Address 837 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location 4430 Belair Rd.

18 (a) Funeral director John J. Conway & Son
(b) Address 701-03 Hollins St.

19 (a) FEB 26 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 1948, at 10:05 M.

21. I certify that I took charge of the remains described above, held an Aug Ed Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G. Kelbaugh M.D. Medical Examiner.
Date signed 2/25/48

VS 151

G60591

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 166

Registered No. G60591

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 14 D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 Argyle Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel J. CARTER

3 (b) If veteran, name war W. W. II

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/9/21

8. AGE: Years 27 | Months 1 | Days 15 | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Rudolph Carter
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Burns
15. Birthplace Va.

16 (a) Informant Mary Carter
(b) Address 1625 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 2/27/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Md.

18 (a) Funeral director Geo. D. Kelson
(b) Address 1303 Pleasant St.

19 (a) FEB 26 1948 (Date rec'd by registrar) **(b)** Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24, 1948, at 12.15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Bullet-wound of abdominal aorta

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-23-48 about 11 p. M.
(b) Where did injury occur? 519 Wash. Blvd. Liquor store Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public **While at work?** No
(d) Means of injury Firearms.

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 2/24/48

VS 181

C60592 Reg. 117535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. C60592

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2024 McCulloh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen Pinn

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Sherman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1909

8. AGE: Years	Months	Days	If less than one day
38	10	4	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward Butler (D)
13. Birthplace Va.

MOTHER
14. Maiden Name Almira Tracy
15. Birthplace Va.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/48 (month) (day) (year)
(c) Cemetery or crematory Lillian
Location Lillian, Va.

18 (a) Funeral director Wm. G. Nelson
(b) Address 1303 Druidmount St

19 (c) FEB 26 1948 Huntington Williams M.D.
(Filed in City Register)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24, 19 48, at 12-45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 17 19 48 to Feb. 24 19 48, and that I last saw her alive on Feb. 24 19 48.

Immediate cause of death	Duration
Uremia.	
Due to Chronic arteriolar nephrosclerosis.	
Due to	
Other Conditions Hypertension. Cardio-vascular Disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William A. Kerkhoff MD
Address Balto City Hosp Date signed 2-25-48

VS 150

X

660593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73a

Registered No. 660593

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1702 E. Federal Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 E. Federal Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLEN NORA McCAWLEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Charles A. McCawley 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17, 1869

8. AGE: Years	Months	Days	If less than one day
78	10	7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Bamberger
13. Birthplace Maryland

MOTHER
14. Maiden Name Ellen Logan
15. Birthplace Maryland

16 (a) Informant Mrs. Elizabeth Duvall
(b) Address 1702 E. Federal Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) FEB 26 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24 1948, at 3 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1938 to Feb. 24 1948, and that I last saw h[illegible] alive on Feb 24 1948.

Immediate cause of death	Duration
Terminal Anemia	12 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. J. Schmeck M.D.
Address 701 N. Howard St. Date signed 2/26/48

VS t50

X

660594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

660594 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hos 15-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 84 6 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 7 (If outside city or town limits, write RURAL and give town)
(d) Street No. 4000 Chatham Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katherine Sander (KATHARINE ELIZABETH SANDER)

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single.
6 (b) Name of husband or wife
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Aug. 21, 1863
8. AGE: Years 84 Months 6 Days 4 If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name George Peter Sander
13. Birthplace Balto

MOTHER
14. Maiden Name Susanna Harvey Daneker
15. Birthplace Balto.

16 (a) Informant Miss Anna M. Ward - Neice
(b) Address 4000 Chatham Rd - C.T.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 27/1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address Baltimore 13 Md.

19 FEB 26 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-25-48 19 10 00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-24 1948 to 2-25 1948 and that I last saw h-r alive on 2-25 1948

Immediate cause of death: Cerebro-vascular accident — Duration: 13 hrs

Due to Arteriosclerotic hypertensive cardio vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dalton R. Williams M.D.
Address Date signed 2/25/48

VS 150

G60595

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH ✓ 94a

Registered No. G60595

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. A. Co.
(c) City or town Greenland Beach (If outside city or town limits, write RURAL and give town)
(d) Street No. (Rural) (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Elmer C Phillipp — CLARENCE ELMER PHILIPP

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Marie

6 (c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): Feb. 23, 1885

8. AGE: Years: 63 | Months: 1 0 | Days: 0 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md (Town, county, and state)

10. Usual Occupation: Philipp Engineering

11. Industry or business: 1129 S. Howard Street

FATHER
12. Name: Henry Philipp
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Catherine Lentz
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Anna Marie Philipp
(b) Address: Greenland, A.A.Co., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2/27/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) FEB 26 1948 (Date rec'd by registrar) (b) Thurlington Williams M.D. Registrar

MEDICAL CERTIFICATION 48

20. DATE OF DEATH: Feb 23 1948, at 2:05 P.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary occlusion

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: Nathan L Kelbach M.D. Medical Examiner.
Date signed: 2/23/48

VS 151

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 060596

060596 C-3865 ✓13B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway.
(c) Hospital or institution:
Church Home & Hosp. 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 N Port St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Virginia Miller

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 24, 1945

8. AGE: Years	Months	Days	If less than one day
2	2	2 13	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation none
11. Industry or business none.

FATHER
12. Name Robert R Miller
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Agnes Guelben.
15. Birthplace Maryland.

16 (a) Informant Mother, Mrs Agnes Miller
(b) Address 119 N Port St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/48 (month) (day) (year)
(c) Cemetery or crematory Chester Cemetery
Location Centerville Md.

18 (a) Funeral director Marvin Williams
(b) Address Chestertown, Md.

19 FEB 26 1948 Registered by Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6, 1948, at 2 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 21 1948, to Feb 26 1948, and that I last saw her alive on 2/25/ 1948.

Immediate cause of death	Duration
Meningitis, acute, c	
Due to Mycobacterium tuberculosis	2 wks.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur [redacted] home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Backenack M. D.
Address 2/26/48 Date signed

Church Home & Hosp X

G60597

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G60597 ✓ 180 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 10 DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 713 Sterling St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elijah Boston

3 (b) If veteran, name war World War I
3 (c) Social Security Account No. 219-07-5194

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Widower

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7 7 1891

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace N. C (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mary Boston Banks
(b) Address 713 Sterling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 21 '48 (month) (day) (year)
(c) Cemetery or crematory BALTO. NATIONAL ~~Mt Lebanon Cem~~
Location BALTO. MD ~~Baltimore County Md~~

18 (a) Funeral director Mrs Cobb & Edwards Dy
(b) Address 1129 N Carlton St

19 (a) FEB 26 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 Feb 1948, at 10:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH asphyxiation
due to carbon monoxide poisoning
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2/21/48 945 P.M. 10/2
(b) Where did injury occur? 713 Sterling Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury House afire

23. Signature Earl L. Royer M.D. Medical Examiner.
Date signed 2/22/48

VS 181

660598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. 660598

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1061 N. Gay St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1061 N. Gay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Mable

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1912

8. AGE: Years	Months	Days	If less than one day
35	8	19	hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Beasley
15. Birthplace N. C.

16 (a) Informant Mabel Robinson
(b) Address 1061 N. Gay St

17 (a) Burial (b) Date thereof Feb 24/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Carmel Cem
Location A. A. County Md

18 (a) Funeral director Mrs Ruth G. Ellis
(b) Address 1129 N. Caroline St

19 (a) FEB 26 1948 (b) Huntington Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1948, at 6.30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection and Ing thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary tuberculosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 2/24/48

VS 151

660599

170714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

90 B

Registered No. 660599

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 E. Eager St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Horace Ward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Martha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-2-90

8. AGE: Years 57 | Months 7 | Days 21 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Fur Repair

11. Industry or business

FATHER
12. Name Richard Ward
13. Birthplace Va

MOTHER
14. Maiden Name Judy
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A A County

18 (a) Funeral director Mrs Robt G. Elliott, Dft
(b) Address 1129 N Eutaw St

19 FEB 26 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-23- 1948, at 8:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1 1947 to 2-23 1948 and that I last saw h[illegible] alive on 2-23 1948.

Immediate cause of death UREMIA

Due to ARTERIOSCLEROSIS OF THE RENAL ARTERIES

Due to

Other Conditions PERICARDITIS UREMIC

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: Above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Freeman J. Hopkins

Address Johns Hopkins Hospital Date signed 2/23/48 D

VS 150

97

660600 117284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 660600

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
6 City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6581 St. Helena Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Frances Lacey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1865

8. AGE: Years	Months	Days	If less than one day
(83)82	4	2	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Patrick Lacey
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Ellwood
15. Birthplace Ireland

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-48 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cemetery
Location Pikesville - Md -

18 (a) Funeral director MARTIN CONROY
(b) Address 1600 Harlem Ave. Baltimore, Md.

FEB 26 1948 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24 1948, at 11-20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 8 1948 to Feb. 24 1948, and that I last saw her alive on Feb. 24 1948

Immediate cause of death	Duration
Pneumonia, Bilateral	1 Wk. 2 days.
Due to	
Due to	
Other Conditions Fracture, left hip (Include pregnancy within 3 months of death)	16 days.

Date of operation 2/11/48
Major findings of operation: Fracture left femur
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 26/6
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 2/8/48 at M
(c) Where did injury occur? Baltimore Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? (Specify type of place)
(e) Means of injury Fall on ice Bathroom (Fall to floor)

23. Signature J. S. Farrate
Address Baltimore City Hosp. Date signed 2/29/48 M. D.

VS 150

To Be Approved By M.E. for Wm. H. Hargrove - Hyattsville, Md. Medicine 2pd 48

G60601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G60601

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 710 N. Augusta Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 710 N. Augusta Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen G. Hofstetter

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W.	Married

6 (b) Name of husband or wife Louis M. Hofstetter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1885

8. AGE: Years	Months	Days	If less than one day
62	6	0	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Moritz Grullmeyer
13. Birthplace Austria

MOTHER
14. Maiden Name Marianne Paarfuss
15. Birthplace Austria

16 (a) Informant Philip L. Hofstetter (Son)
(b) Address 710W. Augusta Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 28/48 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson, Md.

18 (a) Funeral director Harry A. Britzke
(b) Address 4101 Edmondson Ave.

19 (a) FEB 26 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24/48 19 , at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 25, 1946 to Feb. 24, 1948, and that I last saw her alive on Feb. 24, 1948.

Immediate cause of death Cardiac Failure — Duration 6 wks.
Due to Generalized metastasis — Duration
Due to primary carcinoma of the ascending colon — Duration 1 yr.
Other Conditions — Duration
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George A. Kupp M. D.
Address 3030 Edmondson Ave. Date signed 2/25/48

VS 150

G60602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G60602 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City or County: Cloverdale Rd. & Madison Ave
(b) Street address: Temple Garden Apts.
(c) Hospital or institution: 13-7
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days): Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: Temple Garden Apts. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country:

3 (a) FULL NAME: AIMEE GOLDSTROM GAYNOR.

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Wm. A. Gaynor
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 23, 1888.

8. AGE: Years	Months	Days	If less than one day
59	3	3	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Emanuel Goldstrom,
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Augusta Buck,
15. Birthplace: Hartford, Conn.

16 (a) Informant: Mr. William A. Gaynor,
(b) Address: Temple Garden Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2.27.48. (month) (day) (year)
(c) Cemetery or crematory: Hebrew Friendship
Location: Balto. Md.

18 (a) Funeral director: David Sonneborn & Son
(b) Address: 1902 Eutaw Place.

19 (a) FEB 26 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

28. DATE OF DEATH: Feb. 26, 1948, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 12, 1947 to Feb. 26 1948. and that I last saw h[illegible] alive on Feb. 26 1948.

Immediate cause of death	Duration
Carcinoma of Pancreas	5 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation: October 1947.
Major findings of operation: Carcinoma of Pancreas with metastasis to liver.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Joseph W. Ketzky M. D.
Address: 11 E. Chase St. Date signed 2/26/48

C60603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C60603

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
2 City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 350 N. Greene St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susie STEVENS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 80 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Marbourn

13. Birthplace

MOTHER 14. Maiden Name "

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/48 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location 4300 Old Frederick Rd

18 (a) Funeral director H. Zahn & Sons

(b) Address 1318 Light St

19 (a) FEB 26 1948 (b) [illegible] Washington Williams Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23, 1948, at 8 p. M

21. I certify that I took charge of the remains described above, held an Inspection + Exam thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: ~~natural causes~~ ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.

Date signed 2/24/48

X

660604

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. 660604

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6414 Rosemont Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6414 Rosemont Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Henry J. Etzel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Catherine Etzel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1867

8. AGE:

Years	Months	Days	If less than one day
80	4	30 24	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Joseph Etzel
13. Birthplace Md.

MOTHER
14. Maiden Name Mary
15. Birthplace Md.

16 (a) Informant Mrs. Catherine Etzel
(b) Address 6414 Rosemont Avenue

17 (a) Burial (b) Date thereof 2-27-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) Filed FEB 26 1948 (b) Huntington Williams Md
(Registrar's signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23, 1948, at 9.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 - 1945, to Feb 23 - 1948, and that I last saw h him alive on Feb 23 - 1948.

Immediate cause of death angina Pectoris — Duration 3 mos.

Due to — Duration

Due to — Duration

Other Conditions Diabetes — Duration unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chester Riland, M. D.
Address 2532 Edmondson Av Date signed 2-25-48.

94B

660605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

660605 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 902 N. Bond St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 902 N. Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Millie Deshields

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F.
5. Color or race: C.
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Williams
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 28, 1883
8. AGE: Years 64 | Months 11 | Days 24 | If less than one day hr. min.
9. Birthplace Windsor Va.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

MOTHER / FATHER
12. Name Unknown
13. Birthplace
MOTHER
14. Maiden Name Julie Gray
15. Birthplace Windsor Va.

16 (a) Informant Effie Parker
(b) Address 902 N. Bond St
17 (a) Removal (b) Date thereof Feb. 29/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Windsor Va
18 (a) Funeral director Wm. Bott & Elliott Sons
(b) Address 1129 N. Carlisle St.
19 (a) FEB 26 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-24 1948 at 7 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-15 1947 to 2-24 1947 and that I last saw her alive on 2-23 1947.

	Duration
Immediate cause of death: hypertensive cardio-renal disease	Sev. years
Due to (uremia)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rayner Browne M. D.
Address 1500 E. Monument St Date signed 2-26/48

Rayner Browne x

Please write plainly, with pen and ink. Physicians: please write the causes of death clearly and legibly. Do not use abbreviations or symbols. Be sure to answer all questions. Use additional sheet if necessary. Be sure to correct age is especially important.

660606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 660606

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3103 W. North Ave.,
(c) Hospital or institution:

15-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3103 W. North Ave., (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Elisabeth Carr

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or ~~wife~~ James A. Carr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27, 1886

8. AGE: Years	Months	Days	If less than one day
62	0	28	hr. min.

9. Birthplace Baltimore Co., Md. (Town, county, and state)
10. Usual Occupation House-wife
11. Industry or business

FATHER
12. Name Lemuel Compton
13. Birthplace Baltimore Co., Md.

MOTHER
14. Maiden Name Annie Platt
15. Birthplace Baltimore Co., Md.

16 (a) Informant Mr. James A. Carr
(b) Address 3103 W. North Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave.

19 FEB 26 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24, 1948, at 3.50 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to 2-24 1948, and that I last saw h[illegible] alive on 2-22 1948.

Immediate cause of death	Duration
Bleeding Mouth	
Tonsilectomy	3 yrs
Due to Carcinoma of Colon and Sigmoid	unknown
Other Conditions Pharyngitis + Mal nutrition	3 mos

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. B. Emmor, M. D.
Address 7201 York Rd Date signed 4-25-48

VS 150

X

G60607

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

87E

Registered No. G60607

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town ~~Baltimore~~ Ferndale, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 303 Orchard Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Cook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Carroll Cook
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 12/14/1902

8. AGE: Years	Months	Days	If less than one day
42	2	12	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name Fred L. Pensek
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Utz
15. Birthplace Baltimore Md

16 (a) Informant Carol Cook
(b) Address Ferndale, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 1, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Thomas A. Singleton
(b) Address Glen Burnie, Maryland

19 (a) 3-6-1948 (Date received by registrar) (b) Registrar

Huntington Williams, M.D.

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26/48 19 , at M

21. I certify that death occurred on the date above stated, that I attended deceased from 2/16/48 19 , to 2/26/48 19 , and that I last saw h[illegible] alive on 2/26/48 19 .

Immediate cause of death Uraemia - Coma

Due to Pneumonia, lobar

Due to Posterior Fossa Brain Stem Block

Other Conditions Chronic Pulmonary TB.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Asher Wolfe

Address Univ. Hosp. Date signed 3/4/48

G60608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G60608
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 3 days
(e) Length of stay in Baltimore (yrs., mos., or days): 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Talbot
(c) City or town: Avalon
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: James Whalen Harrison

3 (b) If veteran, name war	3 (c) Social Security Account No.
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4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Hattie George Harrison
6 (c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): August 8, 1892

8. AGE: Years	Months	Days	If less than one day
55	6	18	hr. min.

9. Birthplace: Tilghman's Island, Md.
(Town, county, and state)
10. Usual Occupation: Waterman
11. Industry or business: Seafarer

FATHER
12. Name: James Harrison
13. Birthplace: Avalon, Md.

MOTHER
14. Maiden Name: Emily Whalen
15. Birthplace: Wicomico Co. Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 26-48 (month) (day) (year)
(c) Cemetery or crematory FAIR BANK
Location FAIRBANK. MARYLAND

18 (a) Funeral director John. O. Mitchell & Son.
(b) Address 1 & 60 Eutaw Pl.

19 (a) FEB 26 1948 (Date received by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26 19 , at 3:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 23 1948, to Feb. 26 1948. and that I last saw him alive on Feb. 26 19 48

Immediate cause of death 1-Diabetes mellitus
2- Cellulitis left forearm
3- Arteriosclerotic heart disease with myocardial infarction

Duration: 10 yrs about 13 days; Unknown Prior to death

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: William C. Robertson
William C. Robertson, Asst. Surg. (R)
Address: U. S. Marine Hospital Date signed 2/26/48

C60609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C60609

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Lombard & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Herold Harbor, Crownsville P.O.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William F. Casey (William Francis Casey)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Arie Ann Casey
6 (c) If alive, give age 25 years

7. Birth date of deceased (mo., day, yr.) September 19, 1903

8. AGE: Years	Months	Days	If less than one day
44	5	6	....hr. ....min.

9. Birthplace: Annapolis, Md. (Town, county, and state)
10. Usual Occupation: Clerk
11. Industry or business: Fort Meade, Md.

FATHER
12. Name: William F. Casey
13. Birthplace: Annapolis, Md.

MOTHER
14. Maiden Name: Alice Parks
15. Birthplace: Maryland

16 (a) Informant: Mrs. Arie Ann Casey
(b) Address: 123 Market St., Annapolis, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 28, 1948 (month) (day) (year)
(c) Cemetery or crematory: Glen Haven Memorial Cem
Location: Glenburnie, Md.

18 (a) Funeral director: E. Willis Lamoreaux
(b) Address: 1005 W. Baltimore St.

19 (a) Feb 26 1948 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/25/48 19.., at 4.45P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/24/48 19.. to 2/25/48 19.., and that I last saw h[illegible] alive on 2/24/48 19..

Immediate cause of death: resp. failure

Due to: pulmonary edema

Due to: cardiac failure

Other Conditions: anemia, malignant neoplasm of cervix
(Include pregnancy within 3 months of death)

Date of operation: 2/7/48

Major findings of operation: 2/15/48

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: John White, M. D.
Address: Asylum Hosp. Date signed 2/29/48

VS 180

660610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 467

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 da.

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md. (b) County Harford
(c) City or town Bel Air, Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 730 Hickory Ave, Bel Air Md.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Emma Whitaker Myers

3 (b) If veteran, name war ——— 3 (c) Social Security Account No. ———

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mr. Willis Owens Myers
6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) June 13, 1886

8. AGE: Years 61 | Months 8 | Days 13 | If less than one day ——— hr. ——— min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation ———

11. Industry or business ———

FATHER
12. Name Lyman Anson
13. Birthplace Maryland

MOTHER
14. Maiden Name Alice Whitaker
15. Birthplace Maryland

16 (a) Informant Mr. Boyd W. Myers
(b) Address 730 Hickory Ave Bel Air Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 29 48 (month) (day) (year)

(c) Cemetery or crematory Wm Watters Memorial
Location Coolspring Harford Co Md

18 (a) Funeral director Martin Evans
(b) Address Jarrettsville Md

19 (a) ——— (Date received by registrar) (b) Evington Williams M.D. Registrar

FEB 28 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26 1948, at 8 67/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2 1948 Feb. 26 1948.
and that I last saw h[illegible] alive on Feb. 26 1948.

Immediate cause of death	Duration
Pul. Embolism	2 days
Congestive Heart failure	
Due to Rheumatic Heart Dis.	4 yrs
Due to	
Other conditions Carcinoma of Recto-Sigmoid (Include pregnancy within 3 months of death)	

Date of operation 2-14-48
Major findings of operation Ca of Recto-Sigmoid
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. Alford M. D.
Address [illegible] Hosp Date signed 2-26-48

G60611

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

✓ G60611 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 27-12
(b) Street address 3520 N. Hilton Rd.
(c) Hospital or institution: Shriners Nursing Home.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5100 N. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a). FULL NAME Clara M. Hauck.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	W.

6 (b) Name of husband or wife Geo. F. M. Hauck.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27, 1860

8. AGE: Years	Months	Days	If less than one day
87	4	28	hr. min.

9. Birthplace New York. N. Y. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name August Biell
13. Birthplace Germany.

MOTHER
14. Maiden Name Irelander
15. Birthplace

16 (a) Informant Mrs. Thomas S. Haugh.
(b) Address 5100 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-48 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn, Maryland

18 (a) Funeral director Laurence Bryant
(b) Address 5005 Reisterstown Rd.

19 FEB 27 1948 (Date rec'd by Registrar) (b) Lexington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1948, at 11 40 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Feb 25 1948 and that I last saw h-- alive on Feb 24 1948

Immediate cause of death: Cerebral hemorrhage and paralysis — Duration: 5 days

Due to: advanced arteriosclerosis — Duration: ?

Due to:

Other Conditions: Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter D Dunbar M. D.
Address 2220 Garrison Blvd. Date signed Feb 26/48

G60612

BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. G60612

CERTIFICATE OF DEATH 124B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital 8-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1822 E. Lafayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Arthur Davis, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of ~~husband~~ or wife: Rosalie Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-20-1870

8. AGE: Years 78 | Months 0 | Days 6 | If less than one day hr. min.

9. Birthplace Annapolis, Maryland (Town, county, and state)

10. Usual Occupation Pensioner PRR.

11. Industry or business Retired Brakeman

FATHER 12. Name Geo. Davis

13. Birthplace Annapolis Md.

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Catherine R. Davis.

(b) Address 1822 E. Lafayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/48 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

19 (a) MAR 1 1948 (Date rec'd by registrar) (b) Signature of registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-26 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-25 1948 to 2-26 1948, and that I last saw him alive on 2-26 1948.

Immediate cause of death Congestive Failure. Duration.
ARTERIOSCLEROTIC
HEART DISEASE WITH
Due to ACUTE CORONARY
OCCLUSION.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Cardiac Hypertrophy Cirrhosis Liver

of autopsy: Cong. Heart failure

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E May M. D.
Address 1400 N. Caroline St Date signed 2-26-48

VS 150

660613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G60613

GM. 117411 13B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 14 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. None 2926 Elliott st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph E. Debelius

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Div.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21 - 1888

8. AGE: Years 59 | Months 11 | Days 5 | If less than one day hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

MOTHER | FATHER

12. Name Peter Debelius

13. Birthplace France

14. Maiden Name Mary Hoop

15. Birthplace MD.

16 (a) Informant Records Balto. City Hospital

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Parkwood

Location Parkville Md.

18 (a) Funeral director William Cook Inc.

(b) Address 127 St. Paul St.

19 (a) FEB 27 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 26 - 1948, at 11.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2 - 12 - 1948 to 2 - 26 - 1948 and that I last saw him alive on 2 - 26 - 1948.

	Duration
Immediate cause of death: Pulmonary Tuberculosis & Cavitation	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None done

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. T. Benford M. D.

Address Balt City Hosp Date signed 2-26-48

G60614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

132

Registered No. G60614

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution: 8-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3005 Erdman Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: John W. Seegar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Elizabeth F. Seegar

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25, 1877

8. AGE: Years 70 | Months 8 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harry W. Seegar
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Inabelle Frank
15. Birthplace Unknown

16 (a) Informant Mrs. Harvey W. Trail
(b) Address 3005 Erdman Avenue

17 (a) buridal (Burial, cremation, or removal) (b) Date thereof 2/28/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook Mansion
(b) Address 1217 St. Paul Street

19 (a) 1948 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26, 1948, at 12:05 M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18 1948 to Feb 26 1948 and that I last saw h[illegible] alive on 3/25/48 19

Immediate cause of death: Uraemia Convulsions — Duration

Due to Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leon S. Korn, M.D.

Address 2015 Edmondson Date signed 2/26/48

PLEASE WRITE PLAINLY, with INDELIBLE INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

660615 GM. 117577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G60615

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 N. Stricker ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Agnes Beck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21 -1886

8. AGE: Years	Months	Days	If less than one day
62	-	-	hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business Self

FATHER
12. Name Henry Mellon
13. Birthplace Germany

MOTHER
14. Maiden Name Emma Myers
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

FEB 27 1948 (Date rec'd by registrar) (By) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 21 - 1948, at 2.15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2- 18 - 1948 to 2- 21 - 1948, and that I last saw her alive on 2 -21 - 1948.

Immediate cause of death Diabetes Mellitus — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. R. Lemberger M.D.

Address Balto City Hosp Date signed 2-25-48

VS 150

660616

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 660616

1. **PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2101 Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. **USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6118 Greenspring Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** William H. Kettler

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Florence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1868

8. **AGE:** Years 79 | Months 3 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Kettler
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Stern
15. Birthplace Germany

16 (a) Informant Mr. Kenzie H. Kettler
(b) Address 6118 Green Spring Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/48 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) FEB 27 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. **DATE OF DEATH** Feb. 25, 1948 at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1947 to Feb 25 1948 and that I last saw him alive on 2/24 1948.

Immediate cause of death: Chronic Myocarditis — Duration: 2 yrs

Due to: Generalized Arteriosclerosis — Duration: 10 yrs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norman R. Kernan M. D.
Address 3803 Edmondson Ave Date signed 2/25/48

PLEASE WRITE PLAINLY, WITH CONTRASTING INK. Entry must be complete and correct as to every applicable item. Underline the cause to which death should be charged statistically. Physicians: please write the causes of death clearly and legibly. Special attention is called to the importance of correct age.

VS 150

G60617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G60617 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St 25-6

(c) Hospital or institution South Balto General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore 25 (If outside city or town limits, write RURAL and give town)

(d) Street No. 3306 Matson St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Theresa Okros

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Frank Okros

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) May 25, 1874

8. AGE: Years	Months	Days	If less than one day: hr.	min.
73	9	-		

9. Birthplace Hungary (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER

12. Name [redacted] Unknown

13. Birthplace Unknown

MOTHER

14. Maiden Name unknown

15. Birthplace unknown

16 (a) Informant Etta T Okros

(b) Address 3306 Matson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/48 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Annapolis Blvd

18 (a) Funeral director John F Kenny Inc

(b) Address 914 Light St

19 (c) FEB 27 1948 (Date rec'd by local registrar) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1948 at 6 15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 1948 to Feb 25 1948 and that I last saw her alive on Feb 25 1948.

Immediate cause of death Cerebral hemorrhage, right — Duration 2 days

Due to Hypertensive cardiovascular disease and

Due to generalized Carcinomatosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Harold Hilton M. D.

Address South Balto Gen Hospital Date signed Feb 25

VS 150

G60618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G60618 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Levindale Home
(a) Baltimore City, Maryland
(b) Street address Belvedere Ave & Greenspring
(c) Hospital or institution: 15-17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3716 Towanda Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ABRAHAM MASUS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Tavern

FATHER
12. Name Nathan Masus
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Russia

16 (a) Informant Morris Masus
(b) Address 3716 Towanda Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb, 27, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North ave

19 (a) FEB 27 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-26 1948 at 9 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-20 1948 to 2-26 1948
and that I last saw h[illegible] alive on 2-26 1948

Immediate cause of death Cerebral hemorrhage — Duration

Due to

Due to

Other Conditions old hemiplegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Nagel M. D.
Address Levindale Md. Date signed 2-26-48

X

C60619 BC-48-043 42

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. C60619

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Sinai 24-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1527 Covington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby girl Hergtunger

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/25/48

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Nelson Hergtunger
13. Birthplace Baltimore

MOTHER
14. Maiden Name Dorothy Spees
15. Birthplace Balto.

16 (a) Informant Family
(b) Address 1527 Covington St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 2-27-48 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Baltimore Co.

18 (a) Funeral director J. Lee Kenney
(b) Address 1600 S. Fox Tank

19 (a) FEB 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-26 1948 at 6 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-25 1948 to 2-26 1948 and that I last saw h. alive on 2-25 1948.

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M Rumley M. D.
Address Sinai Hosp. Date signed 2-26-48

VS 150

X

660620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 660620

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 15-3
(d) Length of stay in hospital or inst. (yrs., mos., or days): less than 1 day
(e) Length of stay in Baltimore (yrs., mos., or days): ?

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 1819 Moreland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Morris Cohen

3 (b) If veteran, name war: WW I
3 (c) Social Security Account No.: --

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Givner
6 (c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): June 12, 1890

8. AGE: Years: 57 | Months: 8 | Days: 14 | If less than one day: ____ hr. ____ min.

9. Birthplace: Lithuania
(Town, county, and state)

10. Usual Occupation:
11. Industry or business:

FATHER
12. Name: Jacob S. Cohen
13. Birthplace: Lithuania

MOTHER
14. Maiden Name: Eva Cooper
15 Birthplace: Lithuania

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-48 (month) (day) (year)
(c) Cemetery or crematory: Arlington
Location: Rogers Ave.

18 (a) Funeral director: Jack Kaminetz Inc
(b) Address: 206 Huntington Ave. Baltimore, Md.

19 (a) FEB 27 1948 (Date received by registrar) (b) Registrar

VS 139

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26 1948, at 9:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 26 1948 to Feb. 26 1948, and that I last saw him alive on Feb. 26 1948.

Immediate cause of death: Coronary occlusion with heart failure — Duration: 4 days

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: John L. Wilson
Address: John L. Wilson, Sr. Surgeon Clinical Director
Date signed: 2/27/48 M.D.

660621

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. 660621

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution: Mt Sinai Hospital 15-12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2923 Ulman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Goldman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Israel
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15 Birthplace Russia

16 (a) Informant Israel Goldman
(b) Address 2923 Ulman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Pulaski Hy. Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2160 Eutaw Place

19 (a) FEB 27 1948 (Date filed by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-26- 1948 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/24 1948 to 2/26 1948 and that I last saw her alive on 2/24 1948.

Immediate cause of death Acute Coronary Infarction — Duration

Due to Coronary Sclerosis

Due to On Diabetes

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur Hornstein M.D.
Address 704 E Biddle St Date signed 2/26/48

VS 150

X

660622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 660622

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 107 N. Patterson Park Avenue 6-3
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 North Patterson Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ISRAEL ADLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Olga

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 59 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation merchant

11. Industry or business

FATHER 12. Name David

13. Birthplace Russia

MOTHER 14. Maiden Name Leba

15. Birthplace Russia

16 (a) Informant Hyman Adler

(b) Address 107 No Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-48 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Phila Rd + Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 2200 Eutaw Place

19 (a) (Date received by Registrar) FEB 27 1948 (b) Huntington Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26/48 19__, at 11:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Abe R Davis M.D.
Medical Examiner.

Date signed 2/26/48

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

660623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

660623 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MONUMENT ST
(c) Hospital or institution: SINAI 27-17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 2821 W. GARRISON AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MITCHEL M. MILLER

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-09-8822

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ROSE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1896

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace BOSTON MASS (Town, county, and state)

10. Usual Occupation TAILOR

11. Industry or business

FATHER
12. Name MEYER
13. Birthplace RUSSIA

MOTHER
14. Maiden Name IDA
15. Birthplace RUSSIA

16 (a) Informant JACOB MILLER
(b) Address 2821 W. GARRISON AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-27-48 (month) (day) (year)
(c) Cemetery or crematory BNAI ISRAEL
Location SOUTHERN AVE

18 (a) Funeral director JACK LEWIS INC
(b) Address 2100 ENTAW PLACE

19 (a) FEB 27 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26 1948, at 6 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 31 1948, to Feb 26 1948, and that I last saw h. alive on Feb 26 1948.

Immediate cause of death Myocardial Infarction

Due to

Due to

Other Conditions Cardiac Decompensation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Coronary sclerosis - Pulmonary edema

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]

Address [illegible] Date signed 2/26/48 M. D.

VS 150

X

HL. 117523 BALTIMORE CITY HEALTH DEPARTMENT Registered No. 060624

CERTIFICATE OF DEATH 107

060624 SC-48-060624

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospital 8-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 N. Dallis St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME: Leroy Donaldson Baby Boy of Virgie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/16/48

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name James Donaldson

13. Birthplace S.C.

14. Maiden Name Virgie Wilson

15. Birthplace Va.

16 (a) Informant B.C.H. Records

(b) Address 4940 Eastern Avenue

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 9am 2-20-48 (month) (day) (year)

(c) ~~Cemetery or crematory~~ Baltimore City Hospitals

Location 4940 Eastern Ave.

18 (a) Funeral director

(b) Address

19 (a) FEB 27 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18 1948, at 8:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 16, 1948 to Feb. 18 1948, and that I last saw him alive on Feb. 18 1948.

Immediate cause of death	Duration
Pneumonia	2 days
Due to	
Due to	
Other Conditions Atelectasis	2 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julian O. Griffin M. D.
Address Balt. City Hosp. Date signed 21 Feb 48

VS 150

660625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 660625

660625

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 2814

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene Sts.

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 4808 FREDERICK AVE. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Daniel H. Toomey

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	White	Widowed

6 (b) Name of husband or wife: ELLEN M. TOOMEY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1858

8. AGE: Years	Months	Days	If less than one day
89	4	25	hr. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business B & O. R.R.

FATHER

12. Name JOSEPH H. TOOMEY-SR.

13. Birthplace MD.

MOTHER

14. Maiden Name CRISTIAN OURSPRUNG

15. Birthplace PENNA.

16 (a) Informant MISS KATHERINE TOOMEY

(b) Address 4808 FREDERICK AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/28/48 (month) (day) (year)

(c) Cemetery or crematory LOUDON PARK

Location BALTIMORE MD.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address BALTIMORE MD.

19 (a) FEB 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26 1948, at 4 35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 1948 to Feb 26 1948, and that I last saw him alive on Feb 26 1948.

	Duration
Immediate cause of death Uremia	
Due to Generalized Cardio-vascular Collapse	
Due to	
Other Conditions Arteriosclerotic heart disease & decompensation (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible] Jr. M.D.

Address University Hosp. Date signed 2/28/48

X

VS 150

660626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660626

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Tavern - 1801 McKean Ave
(c) Hospital or institution: 15-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1736 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME William F. Wehn

3 (b) If veteran, name war: WW #1
3 (c) Social Security Account No. —

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: ELSIE M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 26, 1881

8. AGE: Years 66 | Months 4 | Days 29 | If less than one day hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business AMERICAN OIL CO.

FATHER
12. Name GEO. F. WEHN
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name SARAH McGUIRE
15. Birthplace BALTIMORE, MD.

16 (a) Informant MR. DONALD F. WEHN
(b) Address 1736 N. FULTON AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/28/48 (month) (day) (year)
(c) Cemetery or crematory BALTO. NAT'L CEM.
Location BALTIMORE, MD.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address BALTIMORE, MD.

19 (a) FEB 27 1948 (Date rec'd by registrar) Signature for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1948, at 4:15 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic cardio vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D. Medical Examiner.
Date signed 2-26-48

VS 191

G60627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G60627

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 313 E. 30th St.
(c) Hospital or institution: 12-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town 313 E 30th St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. BALTIMORE, MD
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) **FULL NAME** MARY JANE FAULKNER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOW

6 (b) Name of husband or wife JOHN E

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 2, 1863

8. AGE: Years	Months	Days	If less than one day
84	8	24	hr. min.

9. Birthplace CARROLL CO., MD.
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business —

FATHER
12. Name JOHN R. FRANK
13. Birthplace CARROLL CO., MD.

MOTHER
14. Maiden Name SUSANNAH SMITH
15. Birthplace CARROLL CO., MD.

16 (a) Informant MRS. JAMES WOLFE
(b) Address 313 E. 30th ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/1/48 (month) (day) (year)
(c) Cemetery or crematory PARKWOOD
Location Balto Co., MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTIMORE, MD.

19 (a) FEB 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26/48 19—, at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 47 to Feb 26 19 48
and that I last saw h— alive on Feb 20 19 48

Immediate cause of death	Duration
Chr. Myocarditis	Indefinite
Due to	
Due to	
Other Conditions paralysis agitans	many years

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathaniel M Beck M.D.
Address 1009 Druid Pk Date signed Feb 27-48

VS 150

X

Please write plainly, with pen or typewriter. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C60628

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937 ✓ Registered No. C60628

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3508 Noble St.,
(c) Hospital or institution: 26-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3508 Noble St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Theodore W. Christian

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Josephine E. Christian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1880

8. AGE: Years 67 | Months 11 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation General work

11. Industry or business National Biscuit Co.,

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Eleanore Schuyler
(b) Address 3508 Noble St-24

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 28 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location City

18 (a) Funeral director Gilbert Funeral Home
(b) Address 2008 Allens Av

19 (a) FEB 27 1948 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION P

20. DATE OF DEATH Feb. 24, 1948, at 5L30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-21-48 19, to 2-24-48 19, and that I last saw h[illegible] alive on 2-21-48 19

Immediate cause of death: Arteriosclerotic Cerebrovascular disease

Due to: Arteriosclerosis

Due to:

Other Conditions: Malignant Anemia

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: 3 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Costantino, M.D.
M. D.
Address 22 E Lombard St Date signed 2-26-48

VS 150

X

G60629

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G60629

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2912 Harford Road
(c) Hospital or institution: 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2912 Harford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** MATILDA AUGUSTA ROSE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Otto

6 (c) If alive, give age 87 years

7. Birth date of deceased (mo., day, yr.) Apr. 23, 1880

8. AGE: Years 67 | Months 10 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Berlin, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Henry Miller

13. Birthplace Germany.

14. Maiden Name Kodner

15. Birthplace Germany

16 (a) Informant Mr. Otto Rose

(b) Address 2912 Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/48 (month) (day) (year)

(c) Cemetery or crematory Emanuel

Location Gunpowder Falls

18 (a) Funeral director J. Hermann & Son

(b) Address 6067 Harford Rd. Huntington Hillcrest, Md.

FEB 27 1948 (a) (b) Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/24/48 19 ..., at 3:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ... at ... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner.

Date signed 2/24/48

660630 117701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181

Registered No. 660630

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 39 N. Randolph Rd. Z.20 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Virginia Maxine Carr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1944

8. AGE: Years 3 | Months 11 | Days 10 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jesse Robert
13. Birthplace Elyria, Ohio

MOTHER
14. Maiden Name Mary Allen
15. Birthplace Orange, Va.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1310 St. Paul st

19 (a) FEB 27 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Feb. 24 1948, at 2-30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 24 1948 to Feb. 24 1948, and that I last saw her alive on Feb. 24 1948.

Immediate cause of death Pulmonary Edema — Duration 10 min.

Due to Asphyxia

Due to Extensive 2nd & 3rd degree burns Extended 1898 — Duration 3 hours

Other Conditions Body surface

(Include pregnancy within 3 months of death)

Date of operation 2-24-48

Major findings of operation: Negative.

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 2-24-48 at 1:00 P M
(c) Where did injury occur? Baltimore County (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Clothes caught fire

23. Signature [illegible] (attending physician) M. D.
Address 4940 Eastern Ave Date signed 2-25-48

VS 150

To Be Approved by M.E. For Dr. Weldon Hufford by Howard J. Mahoney, M.D.

G60631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G60631

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 130 So. Patterson Park Ave
(c) Hospital or institution: St. Joseph Old Age Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore 14 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3034 Maryland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katherine Wysocki

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband ~~wife~~ Michael
6 (c) If alive, give age ~~Deceased~~ years

7. Birth date of deceased (mo., day, yr.) Feb 18 1863

8. AGE: Years 85 | Months - | Days 8 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Paul Kaczka
13. Birthplace Poland

MOTHER
14. Maiden Name Anna ?
15. Birthplace Poland

16 (a) Informant Clara Shaw
(b) Address 3034 Maryland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof ~~Feb~~ 1948 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Park Wood
Location TAYLOR AVE PARKVILLE

18 (a) Funeral director George A Weber
(b) Address 745 S. Ann st

19 (a) FEB 27 1948 (Date rec'd by registrar) (b) Registrar's Signature for Wilmer Mc

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 1948, at 7 44 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to Feb 26 1948, and that I last saw ~~her~~ alive on Feb 25 1948.

Immediate cause of death: Hypertension - Cardio-Vascular Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Andrew Hunsicker M. D.
Address 2559 Eastern Ave. Date signed

C60632 JL - 117329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

Registered C60632

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 1-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 44 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3104 Dillon St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Lasek

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Mary (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1881

8. AGE: Years	Months	Days	If less than one day
67	11	25	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Pete Lasek
13. Birthplace Poland

MOTHER
14. Maiden Name Marianna
15. Birthplace Poland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-48 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore Md.

18 (a) Funeral director George A. Weber
(b) Address 705 So Ann street

19 (a) FEB 27 1948 (Date rec'd by Registrar) (b) Huntingtn Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26, 1948 19, at 6.45am

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1948, to Feb. 26 1948, and that I last saw h. alive on Feb. 26 1948.

Immediate cause of death Carcinoma of hypopharynx with metastases — Duration 6 mos?
Due to
Due to
Other Conditions Arteriosclerosis Heart disease & malnutrition
(Include pregnancy within 3 months of death)
Date of operation 2/23/48
Major findings of operation: Tumor
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. S. Barcat M. D.
Address Baltimore City Hosp Date signed 3/2/48

VS 150

660633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 660633

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1124 W. Cross St.
(c) Hospital or institution: 21-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1124 W. Cross St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara M. B. Perry
3 (b) If veteran, name war ✓
3 (c) Social Security Account No. none
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Wm. H. Perry
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 5/10/1872
8. AGE: Years 75 Months 9 Days 15 If less than one day hr. min.
9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Stivers ?
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs Evelyn Perry
(b) Address 720 Rodney St
17 (a) 2/28/48 (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) Burial
(c) Cemetery or Crematory Westerns
Location Edmonson Ave.
18 (a) Funeral director Walter J. Schwerzbergs
(b) Address 112 W. Cross St.
19 FEB 27 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1948 at 7H. M
21. I certify that death occurred on the date above stated; that I attended deceased from 2-16 1948 to 2-25 1948 and that I last saw her alive on 2-24 1948.

Immediate cause of death: Hypertensive C-V. disease
Cerebral hemiplegy 12

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. Edmund Lewis M.D.
Address 3400 Hilton Rd Date signed 2/25/48

VS 150

X

660634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 660634

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Gunpowder Sanitarium No 3
(b) Street address — Baltimore (291) Md Frederick Rd
(c) Hospital or institution: Gunpowder Sanitarium - Adhel
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Reisterstown
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mattie Ellen Hollingsworth

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1869

8. AGE: Years	Months	Days	If less than one day
78	11	19	hr. min.

9. Birthplace Reisterstown Md (Town, county, and state)
10. Usual Occupation R. H.
11. Industry or business R. H.

FATHER
12. Name John H Hollingsworth
13. Birthplace Md

MOTHER
14. Maiden Name Martha Ellen Price
15. Birthplace Md

16 (a) Informant Spicer/Mrs R B McCloskey
(b) Address Box 301 McLean Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 29, 1948 (month) (day) (year)
(c) Cemetery or crematory Reisterstown Methodist
Location Reisterstown, Md.

18 (a) Funeral director J. F. Eline & Sons
(b) Address Reisterstown, Md.

19 (a) FEB 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1948, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 18 1940 to Feb 26 1948 and that I last saw h alive on Feb 26 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 hr.
Due to Arterio Sclerosis	Years
Due to	
Other Conditions Carcinoma Breast	2 yrs

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred V. Gundry M. D.
Address 3702 Frederick Rd Date signed 2/29/48

VS 2

83a

G60635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44B

Registered No. G60635

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Lombard + Greene
(c) Hospital or institution: University of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County: Carroll
(c) City or town: Manchester. (If outside city or town limits, write RURAL and give town)
(d) Street No.: Main St. (If rural give location)
(e) Citizen of foreign country?: (Yes or No)
If yes, name country:

3 (a) **FULL NAME** Bankert, Raymond

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 24, 1912

8. AGE: Years	Months	Days	If less than one day
36	—		hr. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual Occupation:

11. Industry or business:

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Hospital Records.
(b) Address:

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 2/28/48 (month) (day) (year)
(c) Cemetery or crematory: Bachmans
Location: Carroll Co.

18 (a) Funeral director: Jacob Winks Sons
(b) Address: Manchester, Md

19 FEB 27 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 26 1948, at 5-40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-30 1947 to 2-26 1948, and that I last saw him alive on 2-16 1948.

Immediate cause of death	Duration
Respiratory + Cardiac Failure	
Due to: Anemia	
Due to: General Debility	
Due to: Hodgkins Disease	2 1/2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Not Obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: B. L. Jamison M. D.
Address: University Hosp. Balto Md Date signed 2-26-48

VS 150

G60636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 838

Registered No. G60636

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 Argyle Avve
(c) Hospital or institution: 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 Argyle Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN WALKER

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Mamie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/25/1883

8. AGE: Years	Months	Days	If less than one day
64	2	0	hr. min.

9. Birthplace Dinwitty, Co, Va. (Town, county, and state)
10. Usual Occupation Public Waiter
11. Industry or business

FATHER
12. Name Steven Walker
13. Birthplace Va.

MOTHER
14. Maiden Name Dorothy ?
15 Birthplace Va.

16 (a) Informant Mamie Walker (W.)
(b) Address 1302 Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/29/48 (month) (day) (year)
(c) Cemetery or crematory Bethel Baptist
Location McKenney, Va.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 FEB 27 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/25/48 19 , at 1:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/11 19 48 to 2/25 19 48, and that I last saw him alive on 2/25 19 48.

Immediate cause of death: Cerebral thrombosis — Duration: 7
Due to: Arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carson R. Julian M. D.
Address 1701 Nes. Ave Date signed 2/26/48

VS 150

G60637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G60637

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 304 Wendover Road
(c) Hospital or institution: Home 27-11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 304 Wendover Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Augustus Levering, Jr.

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 215-01 5292

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Florence D. Levering
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) October-3-1879

8. AGE: Years 68 | Months 4 | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Employee of Enterprise
11. Industry or business Fuel Oil Company

FATHER
12. Name Frederick A. Levering
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Webb
15. Birthplace Maryland

16 (a) Informant Mrs. Florence D. Levering (wife)
(b) Address 304 Wendover Road, City #18.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb/28/48 (month) (day) (year)
(c) Cemetery or crematory Springhill
Location Easton, Maryland.

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Avenue, City #1

19 (a) Feb 27 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1948 at 2 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1940 to Feb 26 1948, and that I last saw him alive on Feb 2 1948.

Immediate cause of death	Duration
Coronary Thrombosis	1 hr
Due to Arterio-Sclerosis	Gradual
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Broadley M. D.
Address 140 S Park ave Date signed 2-27-48

Howard J. Morris, M.D.

G60638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G60638

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5601 Flemingo Court
(c) Hospital or institution: 76-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5601 Flemingo Ct-Holibird (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Edward H. Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary E. Harris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1896

8. AGE: Years 51 | Months 9 | Days 20 | If less than one day hr. min.

9. Birthplace Washington, D. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Mary E. Harris
(b) Address 5601 Flemingo Court

17 (a) VBurial (Burial, cremation, or removal) (b) Date thereof 3-1-48 (month) (day) (year)
(c) Cemetery or crematory National Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. BiddleSt.

19 (a) 27 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-25-48 19 , at 10½ M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-13 1948, to 2-25 1948, and that I last saw him alive on 2-24 1948.

Immediate cause of death: Apoplexy
Due to: Hypertension
Due to: wound
Other Conditions: none
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Huntington Williams M.D.
Address 423 New Bittle St. Date signed 2-25-48

C60639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. C60639

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 27-14

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4303 Hewey Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richmond West.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Ada

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-17-1877

8. AGE: Years	Months	Days	If less than one day
70	10	8	hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Richmond West

13. Birthplace N. C.

MOTHER 14. Maiden Name ? ?

15. Birthplace ?

16 (a) Informant Records JOHNS HOPKINS HOSPITAL

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Mem.

Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley

(b) Address 578 W. Biddle St.

19 (a) FEB 27 1948 (Date rec'd by registrar) (b) Huntington Nottingham, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1948, at 4:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24 1948 to Feb 25 1948 and that I last saw him alive on Feb 25 1948

Immediate cause of death	UREMIA	
Due to	ARTERIOSCLEROTIC NEPHRITIS	
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Above

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Freeman D. Hopkins M.D.

Address Johns Hopkins Hosp. Md. Date signed 2-25-48

VS 150

G60640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1248 G60640

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland 8.5

(b) Street address 1400 N Caroline St.

(c) Hospital or institution: St Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1602 Darley Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Frederick Charles Kraus

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-16-1897

8. AGE: Years	Months	Days	If less than one day
50	5	9	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER

12. Name Charles P. Kraus

13. Birthplace Balto. Md.

MOTHER

14. Maiden Name Mary A. Casey

15. Birthplace Balto. Md.

16 (a) Informant Wm. Kraus

(b) Address 2626 Cecil Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/48 (month) (day) (year)

(c) Cemetery or crematory National

Location Frederick Md.

18 (a) Funeral director Wm. H. Valentine

(b) Address 2326 Aisquith St.

19 FEB 27 1948 (Date rec'd by local registrar) (b) Certificate No. Washington Metropolitan

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-25 1948 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-21 1948 to 2-25 1948 and that I last saw him alive on 2-25 1948

Immediate cause of death Portal cirrhosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Robert E May M. D.

Address 1400 N. Caroline St. Date signed 2-25-48

VS 150

G60641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. G60641

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1838 Druid Hill Ave.
(c) Hospital or institution: 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1838 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Caufield Marshall

3 (b) If veteran, name war	3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Norma A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19, 1882

8. AGE: Years	Months	Days	If less than one day
65	11	6	hr. min.

9. Birthplace Baltimore, Md. (town, county and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name Thoroughgood Marshall
13. Birthplace Va.

MOTHER
14. Maiden Name Annie Milligoin
15. Birthplace Va.

16 (a) Informant Mrs. Norma A. Marshall
(b) Address 1838 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co., Md.

18 (a) Funeral director Chas. Sage & H. Holland
(b) Address 1631 Druid Hill Ave.

19 (Date rec'd by registrar) FEB 27 1948 Registrar for Williams [illegible]

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 19 48, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 19 47 to Feb 25 19 48, and that I last saw h 14 alive on Feb 11 19 48.

Immediate cause of death Coronary Thrombosis — Duration 1 yr

Due to

Due to

Other Conditions Medical Management

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Douglas Sheppard M. D.
Address 494 N Eutaw Ave Date signed 2/29/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G60642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G60642 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 19-3
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laura V. Cave (Cavern)

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Harry H. Cave

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12, 1879

8. AGE: Years 68 | Months 5 | Days 14 | If less than one day hr. min.

9. Birthplace Winchester, Va (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Harry H. Cave (Son)
(b) Address 1404 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-1-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Robert C. & R. M. Walters
(b) Address 121 South Stricker Street

19 (a) (b) (Date received by registrar) Registrar

FEB 27 1948

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24 1948, at 3:06 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Multiple head injuries
Congestion of the brain

Due to

Other Conditions Generalized changes incident to arteriosclerosis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2/26/48 at 2:30 P.M.
(b) Where did injury occur? 1404 W. Balto. St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Fell down stairs in home

23. Signature Homer J. Mervis M.D.
Medical Examiner.

Date signed 2-27-48

X

G60643 ✓ G60643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 19-3

(a) Baltimore City, Maryland

(b) Street address JOHN & LAFAYETTE STS.

(c) Hospital or institution:

THE HOSPITAL FOR THE WOMEN OF MARYLAND

(d) Length of stay in hospital or inst. (yrs., mos., or days) 46 DAYS-

(e) Length of stay in Baltimore (yrs., mos., or days) 56 years

2. USUAL RESIDENCE OF DECEASED:

(a) State MARYLAND (b) County

(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1413 W. LOMBARD ST
(If rural give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ESTELLA AMELIA RYAN

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-01-7796

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOWED -

6 (b) Name of husband or wife CHARLES R. RYAN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 9 1891

8. AGE: Years	Months	Days	If less than one day
56	10	16	hr. min.

9. Birthplace BALTIMORE MARYLAND
(Town, county, and state)

10. Usual Occupation CLERK

11. Industry or business HECHT BROTHERS -

FATHER

12. Name JAMES F CONLEY -

13. Birthplace WASHINGTON DC -

MOTHER

14. Maiden Name SARAH E KING

15. Birthplace ELLICOTT CITY, MARYLAND -

16 (a) Informant MRS. HUBERT [redacted]

(b) Address 1413 W. LOMBARD STREET - BALT, MD

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof FEB 28 - 1948 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk

Location Balto Md

18 (a) Funeral director Pott & B. M. Carter

(b) Address Pott & Church St

19 (a) FEB 27 1948 (b) Baltimore, Md. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 25 1948, at 4:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/14/48 1948, to 2/25/48 1948, and that I last saw her alive on FEBRUARY 19 48.

Immediate cause of death Cardiac failure

Due to Coronary atresia

Due to Primary Carcinoma Head of Pancreas

Other Conditions Partial Obstruction of Jejunum, Anemia Secondary Cachexia

(Include pregnancy within 3 months of death)

Date of operation Jan 21 1948

Major findings of operation: Coronary atresia

of autopsy: findings above

Duration
5 mos.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Mark E. Hall, Jr. M. D.

Address Women's Hosp. Date signed 2/26/48

VS 150

X

LILLA F. MIEHLING ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G60644

G60644

The PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 12-6
(b) Street address
(c) Hospital or institution:
Hosp. Women med
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2506 N. Charles St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Lilla F. Miehling

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex female

5. Color or race W.

6 (a) Single, married, widowed, or divorced W. divorced

6 (b) Name of husband or wife Edward Miehling

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June - 24 - 1865

8. AGE: Years 82 | Months 7 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Walton Freeman
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Hodges
15. Birthplace Virginia

16 (a) Informant Edward Heiple
(b) Address 2712 N. Howard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-1948 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto Md

18 (a) Funeral director Bertram Hoffe
(b) Address 2224 N Charles St

FEB 27 1948 Wellington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb - 26 - 1948, at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb - 23 - 1948 to Feb - 26 1948, and that I last saw her alive on Feb - 26 1948.

	Duration
Immediate cause of death Cerebral Hemorrhage Accident	
Due to Arteriosclerotic Hypertension Cardiovascular Disease	
Due to	
Other Conditions Cyst of Kidney	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Confirmed accident

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George H. Williams M. D.
Address Hosp. Women Med Date signed 2/26/48

X

660645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164c

Registered No. 660645

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1743 East 25 Street
(c) Hospital or institution: S-S
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1743 East 25th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Peter P. Sclafani

3 (b) If veteran, name war: 1 World
3 (c) Social Security Account No. 212-10-1613

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1896

8. AGE: Years	Months	Days	If less than one day
51	8	18	hr. min.

9. Birthplace Monte Maggiore, Italy (Town, county and state)
10. Usual Occupation Laborer
11. Industry or business A.S. Ref. Co.

FATHER
12. Name Giuseppe Sclafani
13. Birthplace Italy

MOTHER
14. Maiden Name Cosima Catalano
15. Birthplace Italy

16 (a) Informant Mary Sclafani
(b) Address 1743 E. 25th. Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 29, 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road Gate

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St

19 (a) FEB 27 1948 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26, 1948 at 6.05 A. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of brain

Due to

Other Conditions Mental despondency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2/14/48 at 5.30 A. M.
(b) Where did injury occur? 1743 East 25th St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 2/26/48

G60646
AB-117412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 138

Registered No. G60646

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 2-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1922 Bank Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Szydlowski-

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6-1908

8. AGE: Years	Months	Days	If less than one day
39	10	20	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Walter John Szydlowski-
13. Birthplace Poland

MOTHER
14. Maiden Name Maggie Chmielewski
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-1-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Herman Still Rd.

18 (a) Funeral director Wm. S. Flaherty
(b) Address 1007 Eastern Ave

19 (d) FEB 27 1948 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26 - 1948, at 12.10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-12 - 1948, to 2-26- 1948, and that I last saw h im alive on 2-26- 1948.

Immediate cause of death Pulmonary Tuberculosis — Duration 5 yrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. T. Bamford M. D.
Address Balt. City Hosp. Date signed 2-26-48

VS 150

660647

SC. C. 19862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1576

Registered No. 660647

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) dec
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 830 Fessier St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME James Lee Roger Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 3, 1945

8. AGE: Years 2 | Months 11 | Days 20 | If less than one day .....hr. .....min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name James Lee Rogers Sr.

FATHER 13. Birthplace Md.

MOTHER 14. Maiden Name Ruth Cook

MOTHER 15. Birthplace N. C.

16 (a) Informant James Lee Rogers Sr.

(b) Address 830 - Fessier St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-48 (month) (day) (year)

(c) Cemetery or crematory.....
Location Mt Calvary.

18 (a) Funeral director A. Halstead

(b) Address 918 Druid Hill

19 (a) FEB 27 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 1948, at P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.....
Pulmonary Edema
Acute dilatation of heart

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Earl Roger M.D.
Medical Examiner
Date signed 2-24-48

VS 151

660648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1313

Registered No. 660648

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 4-2
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 220 Myrtle Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country None

3 (a) FULL NAME Charley Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Marguerite

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 4 ?

8. AGE: Years: ? 35 Months: 8 Days: 19 If less than one day: hr. min.

9. Birthplace: Winnsboro S. Carolina
(Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER 12. Name: Thomas Jones

13. Birthplace: S.C.

MOTHER 14. Maiden Name: Emmaline ?

15. Birthplace: S.C.

16 (a) Informant: Marguerite Jones

(b) Address: 220 Myrtle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/48 (month) (day) (year)

(c) Cemetery or crematory: Mt Calvary

Location: A. Halstead

18 (a) Funeral director: 918 Druid Hill Ave.

(b) Address:

19 (a) FEB 27 1948 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/23 1948 at 5:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/22 1948 to 2/23 1948, and that I last saw h M alive on 2/23 1948

Immediate cause of death: Chronic Glomerulo-Nephritis — Duration: 7

Due to:

Due to:

Other Conditions: Uremia

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Wm. Garner

Address: 1514 Division St. Date signed: 2/29/48

VS 150

G60649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. G60649

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D. of A.
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 535 Canal Alley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Mays

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Hospital Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director A. Holstead

(b) Address 915 Edmondson Ave

19 FEB 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/22 1948, at 1:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Nephritis

Due to

Other Conditions Chronic Alcoholism

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. C. Lubinski M.D.
Medical Examiner.
Date signed 2/23/48

C60650

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

Registered No. C60650

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1128 Russell St
(c) Hospital or institution: 21-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 Russell St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edward Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years: 49 | Months | Days | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: Charles William
13. Birthplace: Md

MOTHER
14. Maiden Name: Laura Clark
15 Birthplace: Md

16 (a) Informant: Edward Brown
(b) Address: 1128 Russell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/48 (month) (day) (year)
(c) Cemetery or crematory: Mt Calvary
Location

18 (a) Funeral director: Elroy Allison
(b) Address: 1000 Brantly Ave

19 (a) (Date received by registrar) 2/28/1948 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/24/48 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/20 19 48 to 2/24 19 48, and that I last saw h alive on 2/24 19 48.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Epilepsy	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 1124 Druid Hill Ave Date signed 2/28/48

VS 150

G60651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 B

Registered No. G60651

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1502 Harlem ave
(c) Hospital or institution: 16-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1502 Harlem ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Matilda Gross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years 43 | Months | Days | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Thomas Gross
13. Birthplace Md.

MOTHER
14. Maiden Name Matilda Gross
15. Birthplace Md

16 (a) Informant Charlotte Gross
(b) Address 1502 Harlem ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly ave

19 (a) FEB 27 1948 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26 1948, at 1:15 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 24 1948 to Feb. 26 1948, and that I last saw here alive on Feb. 26 1948.

Immediate cause of death Chr. Nephritis — Duration —

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wallis S. Taylor M. D.
Address 1522 Harlem Ave Date signed 2/26/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G60652

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 48B

Registered No. G60652

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3301 DUDLEY AVE.
(c) Hospital or institution: — — — NONE — — — 26-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3301 DUDLEY AVE. (If rural give location)
(e) Citizen of foreign country? — NO — (Yes or No)
If yes, name country — — — — —

3 (a) FULL NAME MARIE M. LOEFFLER

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: ?

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife: JOSEPH C.

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 6-27-1889

8. AGE: Years 58 | Months 7 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business HOME

FATHER
12. Name ANDREW J. DEEMS
13. Birthplace BALTIMORE

MOTHER
14. Maiden Name CATHERINE GARRICK
15. Birthplace BALTIMORE

16 (a) Informant E. J. DEEMS - BROTHER
(b) Address 3301 DUDLEY AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-1-48 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director LILLY + ZEILER INC.
(b) Address 403 S. WOLFE ST.

19 FEB 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 25 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1947 to Feb. 25 1948 and that I last saw her alive on Feb. 25 1948

Immediate cause of death: Adenocarcinoma of uterus c metastasis to Brain & bone. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. Stevens M.D.

Address 3400 Erdman Ave. Date signed 2/26/48.

VS 150

660653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 660653

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 533 W. Lanvale St
(c) Hospital or institution: — 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 533 W. Lanvale St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary J. Haughton

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Sheppard Haughton deceased

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1868

8. AGE: Years 79 | Months 5 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Catonsville, Md (Town, county, and state)

10. Usual Occupation domestic

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Miss Ella Bantom
(b) Address 533 W. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-29-1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Cockeysville Md

18 (a) Funeral director George T. A. Gibson
(b) Address 1736 Edmondson Ave 17

19 (a) FEB 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1948 at 5:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12. 15. 1947 to 2. 25. 1948 and that I last saw her alive on 2. 25. 1948

Immediate cause of death: arteriosclerotic heart disease — Duration: 2 yrs.

Due to: —

Due to: —

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James D. Carr M. D.
Address 515 Maher St Date signed 2.27.48

VS 3

X

G60654

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. G60654

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 9-8
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 E 22nd St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LEONARD C. BRADY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edw. Brady, Jr.
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Geargan Dayhan
15. Birthplace Balto., Md.

16 (a) Informant Mr. Richard T. Brady
(b) Address 434 Kenneth Square

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem
Location City

18 (a) Funeral director Wiedefeld & Son
(b) Address Greenmount Ave & 22nd

19 (a) FEB 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 1948, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 24 1948, to Feb. 26 1948, and that I last saw him alive on Feb. 26 1948.

Immediate cause of death	Duration
Cardio-respiratory failure	1 day
Due to Hypertension	? years
Due to Chronic Nephritis	? years
Other Conditions Diabetes Mellitus	? years

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy 2/26/48 Chronic Nephritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred H. Dann M. D.
Address Maryland Gen'l Hosp. Date signed 2/26/48

VS 190

1319

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 50

Registered No. G60655

G60655 GH. 117080

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 24-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1045 Williams ST. Z 30 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bertha Kuhlman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17 1876

8. AGE: Years	Months	Days	If less than one day
71	4	9	hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name William Robertson

13. Birthplace MD.

14. Maiden Name Sally Wolford

15. Birthplace MD.

16 (a) Informant records Balto. City Hospita

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Md.

18 (a) Funeral director C. Vernon Lemmon

(b) Address 4611 Park Heights Ave.,

19 (a) FEB 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 26 - 1948, at 1.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 - 31 - 1948 to 2 - 26 - 1948 and that I last saw her alive on 2 - 26 - 1948.

Immediate cause of death	Duration
Cyanosis of breast c widespread pulmonary	4 years
Due to tot loss of weight	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy: same	

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. E. Joyce

Address 4940 Eastern Ave. Date signed 3-1-48

VS 150

X

G60656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G60656 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4826 Park Heights Ave
(c) Hospital or institution: 27-18
(d) Length of stay in hospital or inst. (yrs., mos., or days) more than 3 5 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4826 Park Heights Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patrick H. McCarthy,

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Widower

6 (b) Name of husband or wife Daisy McCarthy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1866

8. AGE: Years	Months	Days	If less than one day
82	1	18	hr. min.

9. Birthplace Baltimore City,
(Town, county, and state)
10. Usual Occupation Retired Foundry Worker
11. Industry or business

FATHER
12. Name Thomas McCarthy,
13. Birthplace Ireland,

MOTHER
14. Maiden Name Mary Farrell,
15. Birthplace West Virginia.

16 (a) Informant Mr. J. W. McCarthy,
(b) Address 5 Hayden Ave. Wilmington Del.

17 (a) burial (b) Date thereof 2/28/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore City,

16 (a) Funeral director L. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.

19 (a) FEB 27 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1948, at 3 P.M.?

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1947 to Feb 26 1948.
and that I last saw him alive on Feb 1948.

	Duration
Immediate cause of death Probably Pulmonary Edema	? 3 hrs.
Due to Arteriosclerotic Heart Disease	20 yrs.
Due to	
Other Conditions Possibly Hodgkin's Disease of Abdominal Aorta	? 1 yr

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard Olsen M. D.
Address 5901 Park Hgts Date signed 2/26/48

VS 150

X

660657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 48B

Registered No. 660657

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5614 York Road

(c) Hospital or institution: 27-17

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5614 York Road (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mattie L. Owings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married~~, ~~widowed~~, or ~~divorced~~.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 20, 1887

8. AGE: Years	Months	Days	If less than one day
60	4	5	hr. min.

9. Birthplace Carroll Co Md (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER 12. Name Thomas H Owings

13. Birthplace Carroll Co Md

MOTHER 14. Maiden Name Peter V. Hatfield

15. Birthplace Carroll Co Md

16 (a) Informant Lillian C Owings

(b) Address 5614 York Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 28 1948 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Woodlawn Md

18 (a) Funeral director John G Mosan

(b) Address 3600 E Baltimore St

19 (a) FEB 27 1948 (Date received by registrar) (b) Lucretia Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25th 1948, at 9.30 A M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to 25 Feb. 1948 and that I last saw her alive on 24 Feb. 1948

Immediate cause of death	Duration
Carcinoma of Body of Uterus with abdominal & rectal metastasis	2 yrs.
Due to	
Due to	
Other Conditions Hypertensive Cardio-Vascular Disease (Include pregnancy within 3 months of death)	2 yrs.

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Wm. H. Kammer Jr. M.D.

Address 501 Sheridan Ave Date signed 26 Feb 48

VS 150

G60658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G60658 / 163 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 9-5
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3204 Loch Raven Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM NORTHAM

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace Winona Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm. T. Northam
13. Birthplace Winona Md

MOTHER
14. Maiden Name Anna Evans
15. Birthplace Deal Island Md

16 (a) Informant Anna Northam
(b) Address Winona

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/48 (month) (day) (year)
(c) Cemetery or crematory St Johns M.E.
Location Deal Island Md

18 (a) Funeral director Fitzgerald
(b) Address Deal Island Md

19 (a) 2/5/48 (Date received by registrar) (b) Huntingtown Williams, Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4, 1948, at 8 P.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Nembutal Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-4-48 at ? M.
(b) Where did injury occur? 3204 Loch Raven Blvd.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Ingestion of nembutal

23. Signature [signature] M.D. Medical Examiner.
Date signed 2-5-48

VS 151

660659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 660659

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Anne Arundel

(c) City or town Marley Park (Glen Burnie P.O.)
(If outside city or town limits, write RURAL and give town)

(d) Street No. Lipscomb Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) ~~FULL NAME~~ IRA J. BECKSWITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife (Mary Lee Beckswith)

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1878

8. AGE: Years	Months	Days	If less than one day
69	4	19	..... hr. ..... min.

9. Birthplace Tyrone, Pennsylvania
(Town, county, and state)

10. Usual Occupation Own Business (Retired)

11. Industry or business Real Estate

FATHER

12. Name Lloyd Beckswith

13. Birthplace Pennsylvania

MOTHER

14. Maiden Name Elizabeth Lockett

15. Birthplace Pennsylvania

16 (a) Informant Mrs. Mary Lee Beckswith

(b) Address Marley Park (Glen Burnie P.O.)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 1, 1948 (month) (day) (year)

(c) Cemetery or crematory Glen Haven Cemetery

Location Glen Burnie

18 (a) Funeral director Thomas W. Singleton

(b) Address Glen Burnie

19 (a) FEB 27 1948 (Date rec'd by registrar) Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/27/48 19..., at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/27/48 19... to 2/27/48 19..., and that I last saw h[illegible] alive on 2/27/48 19...

Immediate cause of death	Duration
Rectal pulmonary edema	
Due to Coronary Thrombosis	
Due to Arterio sclerotic H.D.	
Other Conditions Influenza	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Above - 2nd infarct (H2)

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work?
(Specify type of place)

(e) Means of injury

23. Signature D. O'Brien Jr., M.D.

Address Univ. Hosp. Date signed 2/27/48

VS 150

C60660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (93)

C60660 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2329 Riggs Ave
(c) Hospital or institution: — 16-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 32 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2329 RIGGS AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country —

3 (a) FULL NAME CHARLES CAWANS VIDLER

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 217-01-7868

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 19, 1913

8. AGE: Years	Months	Days	If less than one day
34	7	7	hr. min.

9. Birthplace CUMBERLAND, MD. (Town, county, and state)
10. Usual Occupation DRAFTSMAN
11. Industry or business WESTINGHOUSE ELECT. CO.

FATHER
12. Name CHARLES VIDLER
13. Birthplace HALIFAX, NOVA SCOTIA

MOTHER
14. Maiden Name CLARA M. HYDERBRAND
15. Birthplace CUMBERLAND, MD.

16 (a) Informant MRS. CLARA VIDLER
(b) Address 2329 RIGGS AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/1/48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PK.
Location BALTIMORE, MD.

18 (a) Funeral director WM. J. TICKER & SONS
(b) Address BALTIMORE, MD.

19 (a) [illegible] (Registered by registrar) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26/48 at 4 15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1948 to Feb 26 1948 and that I last saw him alive on Feb 26 1948.

Immediate cause of death Myocardial insufficiency and degeneration. Chronic hypertension with Due to Cardiac hypertrophy and congestive failure

Due to —

Other Conditions Chronic Bronchitis. bronchial asthma. (Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration
3 months
many yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature W. Michel
Address 2901 Edmondson Ave Date signed Feb 27 48 D.

VS 150

FEB 27 48

X

G60661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G60661 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave
(c) Hospital or institution: Church Home & Hospital 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 239 W. Lafayette St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Isabel A DIGGS Lowdenslager

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife ROWLAND LOWDENSLAGER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 25 1900

8. AGE: Years	Months	Days	If less than one day
47	6	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation CLERK - Custom House
11. Industry or business U.S. GOV'T.

FATHER
12. Name Albert Diggs
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Burgess
15. Birthplace Baltimore Md.

16 (a) Informant MR. JAMES B. DIGGS
(b) Address FIRST NATL BANK BLDG.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/28/48 (month) (day) (year)
(c) Cemetery or crematory LORRAINE
Location BALTIMORE CO., MD

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTIMORE, MD.

19 (a) Date rec'd by reg. 1948 (b) Registrar
FEB Washington Williams, MD

VS 1-50

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1948, at 3:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to Feb 27 1948, and that I last saw her alive on Feb 26 1948:

Immediate cause of death: Cardiac failure — Duration
Due to: Pleural effusion
Due to: Advanced Metastatic Carcinoma primary
Other Conditions: Lesion Breast

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Keith Moore M. D.
Address Church Home Hospital Baltimore Md Date signed 2-27-48

660662

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

660662

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 573 - Moore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name)
(d) Street No. 573 - Moore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jenny Perkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5 1848

8. AGE: Years 99 | Months 6 | Days 18 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation domestic.

11. Industry or business

FATHER
12. Name Sherman
13. Birthplace Va

MOTHER
14. Maiden Name Kate ?
15. Birthplace Va

16 (a) Informant Beatrice Kimbrough
(b) Address 573 - Moore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/48 (month) (day) (year)
(c) Cemetery or crematory National Cem.
Location A. Halstead

18 (a) Funeral director
(b) Address 918 - Druid Hill Ave.

19 (a) (Date received by registrar) (b) Registrar

FEB 2 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-23- 1948, at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1948 to Feb 23 1948 and that I last saw h alive on 1948.

Immediate cause of death Cerebral Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 3 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.

Address [illegible] Date signed 2/27/48

G60663

B.C.# 48-03980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G60663 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital 12-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4003 Roland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Mc Cormack (455990)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: ~~Male~~ Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26, 1948

8. AGE: Years 0 | Months 0 | Days 0 | If less than one day: 1 hr. 24 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Bernard A. Mc Cormack
13. Birthplace New York

MOTHER
14. Maiden Name Hermina Gill
15. Birthplace Maryland

16 (a) Informant John Hopkins Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto City

18 (a) Funeral director C. Vernon Leonard
(b) Address 4611 Park Heights Ave.

19 (a) FEB 27 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 1948, at 5:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 26 1948 to Feb. 26 1948 and that I last saw her alive on Feb. 26 1948.

Immediate cause of death - Prematurity
a Atelectasis — Duration 1 hr

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Newton Long M. D.
Address The Johns Hopkins Hospital Date signed 2-24-48

VS 130

X

660664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1240

Registered No. 660664

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + 33rd Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 11 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Hereford
(c) City or town Monkton P. O.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (Hereford) (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. John Wesley Sutton

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-01-9086

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife Mrs. Fairy Sutton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24, 1907

8. AGE: Years	Months	Days	If less than one day
40	11	3	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Coach Driver
11. Industry or business

FATHER
12. Name Mr. Thomas Sutton
13. Birthplace Maryland

MOTHER
14. Maiden Name Georgie Brewer
15. Birthplace Maryland

16 (a) Informant Family, Office - given
(b) Address then by wife

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 / 1 / 48 (month) (day) (year)
(c) Cemetery or crematory Wesley Chapel
Location Monkton, Md.

18 (a) Funeral director Landon M. Crooks
(b) Address Sparks, Md.

19 FEB 28 1948 (Date rec'd by local reg.) (b) Forwarding for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27 1948 at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 16 1948, to Feb 27 1948, and that I last saw h alive on Feb. 27 1948.

Immediate cause of death — Duration
Cirrhosis of Liver — 4 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Cirrhosis of liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel C Buell M.D.
Address Union Memorial Hospital Date signed 4/27/48

VS 150

60665 — E-60665

BALTIMORE CITY HEALTH DEPARTMENT — Registered No. 1634

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 N. Washington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: John L. Griebel

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 218-09-8237

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Lillian Griebel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 13 1893

8. AGE: Years 54 | Months 11 | Days 6 | If less than one day hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Painter

11. Industry or business

FATHER
12. Name: Philip Griebel
13. Birthplace: Germany

MOTHER
14. Maiden Name: Louis Hoffmann
15. Birthplace: Germany

16 (a) Informant: Barbara M. Hawkins
(b) Address: 2109 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-48 (month) (day) (year)
(c) Cemetery or crematory: Balto. Nat'l
Location: Frederick Road

18 (a) Funeral director: John C. Miller Jr.
(b) Address: 345 E. Oliver St

19 (b) APR 20 1948 (Date rec'd by registrar) Washington Hollins Md

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 April 1948, at 8:05 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Carbon Monoxide Poisoning

Due to: Illuminating Gas

Other Conditions: Despondency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4/19/48 at ? A. M.
(b) Where did injury occur? 1312 N. Washington St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury 4 burners and oven of gas range on kitchen gas

23. Signature: Wm. H. Kammer Jr. M.D. Medical Examiner.
Date signed 19 April 1948

660666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. 660666

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1917 E. Hoffman St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 E. Hoffman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louise M. Bostwick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 23rd 1913

8. AGE: Years	Months	Days	If less than one day
34	6	3	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Inmate

11. Industry or business Spring Grove Hospital

FATHER
12. Name John Engler
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs Betty Over
(b) Address 2846 Kentucky Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/1/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) FEB 28 1948 (Date rec'd by registrar) (b) Registered M

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27 1948, at 11:30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑; accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema & congestion

Due to

Other Conditions Hypertrophy - dilatation of Heart; Acute congestion of all Lungs. (Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Thomas J. Mullen M.D. Medical Examiner.
Date signed 2-27-48

VS 181

111c

660667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. 660667

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 211 E. 25 St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 E. 25th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: DeCare Mildred WETHERBY (Bell C. Wetherby)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of ~~husband or~~ wife Leverne C. Wetherby
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12th 1902

8. AGE: Years	Months	Days	If less than one day
46	8	4/7	hr. min.

9. Birthplace Nashville Tenn.
(Town, county, and state)
10. Usual Occupation Hair Dresser
11. Industry or business Edythe Beauty Shop

FATHER
12. Name Jesse B. Davidson
13. Birthplace Tenn.

MOTHER
14. Maiden Name Gertrude M. E
15. Birthplace Tenn.

16 (a) Informant Leverne C Wetherby
(b) Address 211 E. 25th St.

17 (a) Cremation (b) Date thereof 3/1/48
(Burial, cremation, or removal) (month) (day) (year)
(c) ~~Cemetery or~~ crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) FEB 28 1948 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26, 1948, at 8:15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Lobar pneumonia (right lung)

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 2/26/48

VS 181

X

660668

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1948

Registered No. 660668

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 W. ROGERS Ave
(c) Hospital or institution: HOMME FOR THE AGED of the Methodist Chh
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 YRS.
(e) Length of stay in Baltimore (yrs., mos., or days) 43 YRS 2 9 45

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 W. ROGERS Ave (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country

3 (a) FULL NAME SARAH E. JOHNSON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. WIDOW

6 (b) Name of husband or wife JOSEPH JOHNSON

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 17, 1864

8. AGE: Years 83 | Months 9 | Days 9 | If less than one day ..... hr. ..... min.

9. Birthplace BALTIMORE CO. MD. (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER 12. Name JOHN WESLEY BULL

13. Birthplace BALTO CO., MD

MOTHER 14. Maiden Name LOUISA WILLIAMS

15. Birthplace BALTIMORE CO., MD

16 (a) Informant JANET B. THOMAS - TRENS.

(b) Address 2211 W. ROGERS AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/1/48 (month) (day) (year)

(c) Cemetery or crematory BALTIMORE CEM.

Location BALTO., MD.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address BALTIMORE, MD.

19 (a) FEB 28 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26/48 19—, at 2:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/17 19 48 to 2/26 19 48 and that I last saw h alive on 2/26 19 48.

Immediate cause of death Cerebral Hemorrhage (Left Hemiplegia)

Due to Cardiovascular Disease

Due to Cerebral arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles L. Warner M. D.

Address 429 Med-Arts Bldg Date signed 2/27/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 159

C60669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 100 B

Registered No. C60669

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2724 W. Charles St.
(c) Hospital or institution: Sinai Hosp. 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4108 NEWTON AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SYLVESTER K GUDLEY

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: YES

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	MARRIED

6 (b) Name of husband or wife: KATHERINE M.
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) SEPT 8, 1892

8. AGE: Years	Months	Days	If less than one day
55	5	19	hr. min.

9. Birthplace: Lithuania (Town, county, and state)
10. Usual Occupation: Tailor
11. Industry or business: —

FATHER
12. Name: KLETUS GUDLEY
13. Birthplace: LITHUANIA

MOTHER
14. Maiden Name: PAULINE MORKIS
15. Birthplace: LITHUANIA

16 (a) Informant: Mrs Kathryn Gudley
(b) Address: 4108 Newton Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/1/48 (month) (day) (year)
(c) Cemetery or crematory: HOLY REDEEMER
Location: BALTIMORE, MD.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: BALTIMORE, MD.

19 (a) FEB 28 1948 (Date received by registrar) Huntington Willard, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Feb 1948, at 4 15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9 Feb 1948, to 27 Feb 1948, and that I last saw h.i.m. alive on 27 Feb 1948.

Immediate cause of death	Duration
Acute cardiac failure following operation of vena cava (ligation)	
Due to	
Due to Thrombophlebitis, Rt. Leg.	2 weeks
Other Conditions Pulmonary infarct (right lower lobe)	2 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Harold M. Hamburger M.D.
M. D.
Address: Sinai Hosp. Date signed 27 Feb 48

VS 150

660670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 660670

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 W. University Pky.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE, MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 W. UNIVERSITY PKY.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME LILA CHAPMAN LUSBY.

3 (b) If veteran, name war NONE
3 (c) Social Security Account No. NONE

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. WIDOW

6 (b) Name of husband or wife HARRY A. LUSBY
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) JAN 7, 1866

8. AGE: Years 82 | Months 1 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation NONE
11. Industry or business —

FATHER
12. Name WILLIAM BOYLE
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name MARGARET T. CALDWELL
15. Birthplace BALTIMORE, MD.

16 (a) Informant MRS. J. MC CARTER
(b) Address 100 W. UNIVERSITY PKY.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/28/48 (month) (day) (year)
(c) Cemetery or crematory DRUID RIDGE
Location PIKESVILLE, MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address NORTH & PA. AVES., BALTO., MD.

19 (a) FEB 28 1948 (Date rec'd by registrar) (b) Tunstington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26 1948, at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 13 1947, to Feb. 26 1948, and that I last saw her alive on Feb. 25 1948.

	Duration
Immediate cause of death: 1) Cerebral Hemorrhage 2) Recurrent.	4 months.
Due to	
Due to	
Other Conditions: Hypertensive Heart Disease (Include pregnancy within 3 months of death)	10 yrs.

Date of operation — None
Major findings of operation:
of autopsy: — No.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Earl F. Chambers M. D.
Address 4108 Liberty Hts Date signed 2/27/48

83a

G60671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1121a

Registered No. G60671

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 W. ROGERS AVE.
(c) Hospital or institution: METHODIST HOME FOR THE AGED
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day 11 Hours
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 W. ROGERS AVE. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

15

3 (a) FULL NAME ERNEST CAMPBELL

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	WIDOWER

6 (b) Name of husband or wife UNKNOWN (DECEASED)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8/23/1863

8. AGE: Years	Months	Days	If less than one day
84	6	2	hr. min.

9. Birthplace BALTIMORE, MD (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name KENNETH CAMPBELL
13. Birthplace SCOTLAND

MOTHER
14. Maiden Name ELIZABETH BALSTER
15. Birthplace BALTIMORE, MD.

16 (a) Informant MRS. MAMIE B. FISHER
(b) Address 2211 W. ROGERS AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/28/48 (month) (day) (year)
(c) Cemetery or crematory DRUID RIDGE
Location PIKESVILLE, MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTIMORE, MD

19 (a) FEB 28 1948 (Date rec'd by registrar) (b) Cuthbert Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB 26, 1948, at 10 22 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24 1948 to Feb 26 1948 and that I last saw him alive on Feb 25 1948.

Immediate cause of death Myocarditis — ? Duration
Due to Cardio-renal sclerosis
Due to Chr. glomerular Nephritis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify public place) While at work?
(e) Means of injury

23. Signature Charles L. Warner M. D.
Address 421 Med. Arts Bldg. Undertaker

2/26/48

660672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

660672 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 DENISON ST.
(c) Hospital or institution: CRAWFORD RETREAT
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2835 Clifton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country —

3 (a) FULL NAME LUCY ANN SERVICE

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No.: NONE

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: WIDOW
6 (b) Name of husband or wife: GEO. D. SERVICE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): OCT. 25, 1863

8. AGE: Years 84 | Months 4 | Days 1 | If less than one day: hr. min.

9. Birthplace: ONTARIO, CANADA. (Town, county, and state)

10. Usual Occupation: HOUSEWIFE.

11. Industry or business —

FATHER
12. Name: UNKNOWN
13. Birthplace: CANADA

MOTHER
14. Maiden Name: UNKNOWN
15 Birthplace: CANADA

16 (a) Informant: MR. HAROLD P. SERVICE
(b) Address: 2835 Clifton Ave

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/28/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~: WOODLAWN
Location: BALTO CO. MD

18 (a) Funeral director: WM. J. PICKNER & SONS
(b) Address: Balto. MD

19 (a) FEB 28 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26 1948, at 4 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 14 1948 to Feb 26 1948, and that I last saw h[illegible] alive on Feb 26 1948.

	Duration
Immediate cause of death: Anemia	
Due to: asteroid sclerosis & senility	
Due to:	
Other Conditions:	
(Include pregnancy within 3 months of death)	
Date of operation:	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 3033 W North Ave. M.D. Date signed 2/24/48

VS 150

X

G60673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. G60673

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2323 W. LAFAYETTE ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2323 W. LAFAYETTE ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EUSEBIA DORRIDA

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	WIDOW

6 (b) Name of husband or wife ALBERT E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) NOV. 6, 1870

8. AGE: Years	Months	Days	If less than one day
77	3	20	hr. min.

9. Birthplace CHURCHVILLE, MD.
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name JOHN A. DAY
13. Birthplace MD.

MOTHER
14. Maiden Name MARY BARNETT
15 Birthplace MD.

16 (a) Informant N. E. DORRIDA.
(b) Address 2118 CHELSEA TERR.

17 (a) BURIAL (b) Date thereof 2/29/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ANGELS HILL
Location HAVRE DE GRACE, MD

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTO., MD.

19 (a) FEB 28 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26/48 at 5-30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/21 1947, to 2-26 1948 and that I last saw her alive on 2-26 1948.

	Duration
Immediate cause of death: Acute Pulmonary Oedema	3 days.
Due to: congestive Hypertrophy + dilatation	3 MO.
Due to:	
Other Conditions: arteriosclerosis - general.	10 yrs.
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. A. Glenn M. D.
Address Temple Gordon Apt. Date signed 2/27/48

VS 190

X

Dr. White

660674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 660674

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2913 Louise Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2913 Louise Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH (BESSIE) VONDER SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife William Forris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20, 1884

8. AGE: Years	Months	Days	If less than one day
63	3	5	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Thomas Ruckle
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Ward
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Wm. F. Vonder Smith
(b) Address 2913 Louise Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) FEB 28 1948 (Date rec'd by registrar) (b) Huntington Station, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1948, at 10:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1st 1947 to Feb. 25 1948, and that I last saw her alive on Feb. 25 1948.

Immediate cause of death	Duration
Chronic Myocarditis.	2 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation No

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James F. White M. D.
Address 422 Euston Ave, Baltimore 21, Md. Date signed 2/27/48

VS 150

660675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 660675

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1135 Harlem ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1135 Harlem ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Pindle

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1913

8. AGE: Years	Months	Days	If less than one day
34	10	11	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name William Pindle
13. Birthplace Md

MOTHER
14. Maiden Name Ella Offer
15. Birthplace Md

16 (a) Informant William Pindle
(b) Address 1135 Harlem ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 2-29-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George H. Nelson
(b) Address 1303 Presstman St

19 FEB 28 1948 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/24 19 48 at 9A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/20 19 47 to 2/24 19 48.
and that I last saw her alive on 2/23 19 48.

Immediate cause of death	Duration
(a) Leukemia Rt. Meningeal Hemorrhage	2 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. J. Hatcher
Address 1725 Pulaski Date signed 2/27/48

VS 150

660676

BALTIMORE CITY HEALTH DEPARTMENT X ✓

CERTIFICATE OF DEATH 55E

Registered No. 660676

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St & Lenidon Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 days
(e) Length of stay in Baltimore (yrs., mos., or days) 33 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Wicomico
(c) City or town Salisbury
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 Light St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Oland Phillips

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 214-10-9177

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife M. Marion Phillips
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) July 17, 1887

8. AGE: Years	Months	Days	If less than one day
60	7	10	hr. min.

9. Birthplace Laurel Del (Town, county, and state)
10. Usual Occupation Ship Builder
11. Industry or business

FATHER
12. Name George W. Phillips
13. Birthplace Del.

MOTHER
14. Maiden Name Elizabeth J. Bradley
15. Birthplace Del

16 (a) Informant M. Marion Phillips
(b) Address 313 Light St. Salisbury Md

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Mar 1, 1948 (month) (day) (year)
(c) Cemetery or crematory Wicomico Memorial Cem
Location Salisbury - Md

18 (a) Funeral director Mr & Mrs. John W. Tindel Son
(b) Address 5311 Edmondson Ave

19 (a) FEB 28 1948 (Date received by registrar) (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Feb 1948, at 9:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 24 Jan 1948 to 27 Feb 1948 and that I last saw h alive on 27 Feb 1948

Immediate cause of death: Generalized carcinomatosis cancer ambucavon — Duration: 6 mo?

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. Allen Spicer M. D.
Address Md. Gen. Hosp Date signed 27 Feb

VS 150

X

G60677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G60677

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3003 Presstman St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 81-6-30

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3003 Presstman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Andrew W. Beveridge

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-16-8800

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Widower

6 (b) Name of husband or wife Emma A. Beveridge

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27-1866

8. AGE: Years	Months	Days	If less than one day
81	6	30	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Printer

11. Industry or business Joseph J. Slavin Sons

FATHER
12. Name John Beveridge
13. Birthplace Scotland

MOTHER
14. Maiden Name Elizabeth Williamson
15. Birthplace Scotland

16 (a) Informant Mrs. Ruth B. Savage
(b) Address 3003 Presstman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director L. Howard Strong
(b) Address 3707 W. North Ave.

19 (a) FEB 28 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 245

20. DATE OF DEATH Feb. 26 1948, at 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from December 1946, to Feb 26 1948, and that I last saw h. alive on Feb 25 1948

Immediate cause of death	Duration
Chronic Myocarditis	?
Due to Senility	?
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature D. Walter Spurrier M.D.
Address 3603 Edmondson Ave (Date signed 2/27/48)

VS 150

660678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660678

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 409 S. Dallas St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME: Henry Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866 or 1869

8. AGE: Years 81-or-78 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Green
13. Birthplace Maryland

MOTHER
14. Maiden Name Lucy McDoney
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-29-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. Co., Md.

18 (a) Funeral director Josiah L. Brown & Son
(b) Address 108 W. Montgomery St.

19 (a) FEB 28 1948 (Date rec'd by registrar) Attesting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24 1948 at 3.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-7- 1927 to 2-24- 1948 and that I last saw him alive on 2-24- 1948.

Immediate cause of death: Pulmonary Tuberculosis
Bronchopneumonia
Due to
Due to
Other Conditions Malnutrition
Generalized arteriosclerosis
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy: Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. T. Bamford M. D.
Address Balt. City Hosp. Date signed 2-26-48

VS 150

660679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660679

BC: 48-04635 1579

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1918 Wilkens Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby CAMPBELL, LAWRENCE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-27-48

8. AGE: Years — | Months — | Days 2/5 | If less than one day — hr. — min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Howard D Campbell
13. Birthplace Md

MOTHER 14. Maiden name Harland Wiedewitsch
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 28/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick ave

18 (a) Funeral director Harry Hutzler's
(b) Address 4101 Columbus Ave

19 (a) FEB 28 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/27/48 19 , at 6:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/26/48 19 , to 2/27/48 19 , and that I last saw him alive on 2/27/48 19 .

Immediate cause of death Diaphragmatic hernia — Duration 4 hr

Due to Congenital

Due to

Other Conditions Gastric perforation

(Include pregnancy within 3 months of death)

Date of operation 2/26/48

Major findings of operation: As above.

of autopsy: Same

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry F. Bahnson M. D.
Address HH Date signed 2/29/48

VS 150

C60680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. C60680

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 932 Chauncey Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-1
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 932 Chauncey Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME ADELE ZINSER COOKE.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Wm. Emmitt Cooke.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1881.

8. AGE: Years	Months	Days	If less than one day
66	9		hr. min.

9. Birthplace Germany. (Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER
12. Name Adolph Zinser,
13. Birthplace Germany.

MOTHER
14. Maiden Name Clementine Neuburger,
15. Birthplace Germany.

16 (a) Informant Mr. Sol Zinser,
(b) Address 932 Chauncey Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2.29.48. (month) (day) (year)
(c) Cemetery ~~or crematory~~ Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director David Lindenwood Sons
(b) Address 1902 Eutaw Place.

19 (c) Feb 28 1948 Huntington Williams M.D.
Date Received Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27th. 1948, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24 1948 to Feb 27 1948 and that I last saw her alive on Feb 27 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Hypertension	3 yrs
Due to arterio-sclerosis	"
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Freiserman Lantz M. D.
Address Temple Garden Apts. Date signed 2/28/48

VS 150

G60681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G60681

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3020 E Baltimore St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Josephine [redacted] Sophia (Smudzinewska) Schultz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: Mr. Frank Schultz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1883

8. AGE: Years 65 Months 1 Days 10 If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Chmielewska
13. Birthplace Poland

MOTHER
14. Maiden Name Marcella Nawakowski
15. Birthplace Poland

16 (a) Informant Mr. Frank [illegible] Schultz
(b) Address 3020 E. Baltimore St.

17 (a) Burial (b) Date thereof 3/1/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus
Location Dundalk ave Balto, Md.

18 (a) Funeral director Schmunck Funeral Home
(b) Address 2601-5 E. Madison St.

19 (a) FEB 29 1948 (b) Huntington W. Va. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26 1948, at 7:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1948 to Feb 26 1948, and that I last saw h.e alive on Feb 26 1948.

Immediate cause of death	Respiratory failure	
Due to	uraemia	
Due to	generalized carcinomatosis	
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation 2/17/48

Major findings of operation: generalized carcinomatosis

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James A. Schultz Jr.

Address Bon Secours Hospital Date signed 2/26/48 M. D.

X

G60682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

G60682 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 419 S. Bentalou St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 419 S. Bentalou St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Margaret (Maggie) Wilhelmina Kuhl

3 (b) If veteran, name war None | 3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Francis Kuhl
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 7, 1873

8. AGE: Years 74 | Months 11 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Unknown
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Maryland

16 (a) Informant Walter Kuhl
(b) Address 313 N. Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-1-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Maryland

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave.

19 (a) 2/29/48 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27, 1948, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1, 1946 to Feb 27 1948, and that I last saw h[illegible] alive on Feb 25, 1948

Immediate cause of death Myocardial failure. — Duration one day

Due to Rheumatic cardio-vascular disease — Duration Approx. 15 yrs

Due to

Other Conditions Arteriosclerosis Generalized.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. T. Battaglia M.D. M. D.
Address 582 S. Belair Rd Date signed 2/29/48

VS 150

Huntington-Williams

X

660683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

660683 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospitals 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) (18 days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1236 Carroll St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert W. Lusby

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: ~~Married~~ Divorced

6 (b) Name of husband or wife: Addie Lusby
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1, 1869

8. AGE: Years 78 | Months 6 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name Charles Lusby
13. Birthplace Maryland

MOTHER 14. Maiden Name Cornelia Davis
15. Birthplace Virginia

16 (a) Informant Mary E. Linthicum
(b) Address 2003 McHenry Street

17 (a) Burial (b) Date thereof 3-1-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave.

19 (a) FEB 29 1948 Washington, Baltimore, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27, 1948, at 8:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractures of skull, ribs, and pelvis.
~~Due to~~ Dislocation of left shoulder.
Syphilitic aortitis.
~~Other Conditions~~ Myocardial hypertrophy and degeneration.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Feb. 27, 1948 at 8:45 A. M. 26/12
(b) Where did injury occur? Infirmary - Balto. City Hosp.
(c) Did injury occur at home, on farm, industrial place, in public place? Hospital While at work?
(d) Means of injury Slipped and Fell down stairs - died result of fractures

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 2/27/48

VS 191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G60684

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 54a

G60684 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Radewood & Green Sts.
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 13 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 Presbury St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Silverman

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-1729

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Rae Nee Neurick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec, 25, 1898

8. AGE: Years	Months	Days	If less than one day
49	2	3	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business Clothing Cutter

FATHER
12. Name Max Silverman
13. Birthplace Russia

MOTHER
14. Maiden Name Anna ?
15. Birthplace Russia

16 (a) Informant Rae Silverman
(b) Address 2015 Presbury St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 28, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men Cem
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) 2 29 1948 (Date rec'd by registrar) Thurston Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/28/48 19 , at 2 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/25/48 19 , to 2/28/48 19 , and that I last saw h[illegible] alive on 2/28/48

Immediate cause of death Respiratory Failure
Due to Medullary Compression
Due to Cerebral Edema
due to Bleeding of Left
~~Other Conditions~~ fronto-temporal region

(Include pregnancy within 3 months of death)

Date of operation 2/26/48

Major findings of operation: Abscess of left fronto-temporal region

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank Brumback M.D.
Address University Hosp. Date signed 2/28/48

Frank Brumback X

G60685

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G60685
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MONUMENT ST. & ROTLAND AV.
(c) Hospital or institution: SINAI HOSPITAL OF BALTO. 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE. (If outside city or town limits, write RURAL and give town)
219
(d) Street No. LEVINDALE AGED HOME. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY COHEN.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Late Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 62 | Months | Days | If less than one day: hr. min.

9. Birthplace RUSSIA. (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Kadish Cohen
13. Birthplace Russia

MOTHER
14. Maiden Name Hannah ?
15. Birthplace Russia

16 (a) Informant Jerome Cohen
(b) Address 2814 Baker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb, 29, 1948 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave Sol Levinson & Bros

18 (a) Funeral director 1124-1126 W. North Ave
(b) Address

19 (a) 28 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 26 1948 at 7.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from FEB 24 1948 to FEB. 26, 1948.
and that I last saw him alive on FEB. 26, 1948.

Immediate cause of death	Duration
Pulmonary edema.	
Due to Arteriosclerotic CVD.	
Due to	
Other Conditions Popliteal embolism, right.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irvin M. Lushner M. D.
Address Sinai Hospital Date signed 2-26-48

VS 150

G60686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G60686

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3503 Lucille Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Otto Alter Tourkin

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of ~~husband or~~ wife Bertha
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation
11. Industry or business Carpenter

FATHER
12. Name David Tourkin
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Richard Tourkin
(b) Address 530 10 th St. Wash. DC. SW

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 29/48 (month) (day) (year)
(c) Cemetery or crematory Hebre Young Men Cem
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1124-26 W. North Ave.

19 (a) Thurlington Williams, M.D. Registrar
(Date rec'd by registrar) FEB 29 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27, 1948 19 at 9.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1947 to Feb 27 1948, and that I last saw him alive on Feb 27 1948.

Immediate cause of death	Duration
Carcinoma of rectum	1 year
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Manuel Levin
Address 4818 Reisterstown Rd Date signed M. D. 2/28/48

X

BC 55878
G60687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

G60687 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mon
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 237 S. Regester St (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Carmine E. Runk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8, 1946

8. AGE: Years	Months	Days	If less than one day
1	5	27	hr. min.

9. Birthplace Baltimore Md (Town, county and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Clayton E. Runk
13. Birthplace Baltimore

MOTHER
14. Maiden Name Marie Kalb
15. Birthplace Baltimore

16 (a) Informant Mr. Clayton E. Runk
(b) Address 237 S. Regester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/2/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Park
Location Taylor Ave

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 4914 Belair Road.

19 FEB 29 1948 Registered by registrar Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 1948 at 2:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18 1948 to Feb 22 1948, and that I last saw him alive on Feb 22 1948.

Immediate cause of death Influenza
malignant

Due to Influenzal Bacillus Type B

Due to

Other Conditions Hydrocephalus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. A. Faranio

Address Mercy Hosp Date signed 2/29/48 M. D.

VS 150

33B

660688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

660688

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 3932 Reisterstown Road
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3932 Reisterstown Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lewis William Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-22-2420

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Pa (Town, county, and state)
10. Usual Occupation
11. Industry or business Salesman

FATHER
12. Name Unknown
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Mr Cohen
(b) Address 309 N Arlington ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 29/48 (month) (day), (year)
(c) Cemetery or crematory Hebrew Rockdale Cem
Location Hamilton ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) FEB 29 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27 1948, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1947 to Feb 27 1948 and that I last saw him alive on Feb 27 1948.

Immediate cause of death: Coronary Thrombosis — Duration: Instant

Due to: Cardiac Hypertrophy + Hypertension — Duration: about 1 yr.

Due to — Duration:

Other Conditions — Duration:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Reuben M. Kotzen M.D.
Address 3700 Park Heights Date signed Feb 29 1948

VS 150

X

G60689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G60689 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-47
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris ~~[illegible]~~ DUBIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Leah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1849

8. AGE: Years	Months	Days	If less than one day
99			hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

MOTHER / FATHER

12. Name Moh Kuvow

13. Birthplace Germany

14. Maiden Name Moh Kuvow

15. Birthplace Germany

16 (a) Informant Mrs Chas. Dubansky

(b) Address 2313 Chelsea Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-29-48 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 2100 Eutaw Place, Md

19 (a) (b) (Date filed by registrar) Registrar

2 29 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28th 1948, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15th 1948, to Feb 28th 1948, and that I last saw h[illegible] alive on Feb 27th 1948.

Immediate cause of death	Duration
Acute heart failure	
Due to Senile arteriosclerosis and debility	
Due to Senility	
Other Conditions Chronic obstruction of bladder (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome J. Blumberg M. D.

Address Levindale Home Date signed 3/2/48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G60690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G60690 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3800 Park Heights Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-12
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3800 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes name country

3 (a) FULL NAME Carroll Maynen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jennie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 70 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Katie
15. Birthplace Russia

16 (a) Informant Jennie Maynen
(b) Address 3800 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-29-48 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Boulevard

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) 2 29 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27-1948 at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947 to 2/27 1948 and that I last saw him alive on 2/22, 1948.

Immediate cause of death: Arteriosclerosis & Cardiovascular Disease — Duration: Few years
Due to
Due to
Other Condition: Acute myocardial failure — Duration: 12 hours
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A A Sussman M.D.
Address 1109 N. Calvert St Date signed 2/28/48

VS 150

A.A. Sussman X

G60691 BALTIMORE CITY HEALTH DEPARTMENT G60691
Registered No.

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1823 N. PULASKI ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-2
(e) Length of stay in Baltimore (yrs., mos., or days) 52 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 1823 N. PULASKI ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HANNAH WOLFSON
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOW
6 (b) Name of husband or wife: BENJAMIN
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1872
8. AGE: Years 76 | Months | Days | If less than one day ..... hr. ..... min.
9. Birthplace: RUSSIA (Town, county, and state)
10. Usual Occupation: NONE
11. Industry or business

FATHER
12. Name JOSEPH
13. Birthplace RUSSIA

MOTHER
14. Maiden Name HILDA
15 Birthplace RUSSIA

16 (a) Informant HARRY WOLFSON - SON
(b) Address 1823 N. PULASKI ST
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-29-48 (month) (day) (year)
(c) Cemetery or crematory ADAS ISRAEL
Location NORTH POINT RD
18 (a) Funeral director JACK LEWIS INC
(b) Address 2100 EUTAW PLACE
19 (a) FEB 29 1948 Huntington Williams M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-26 1948, at 6 A. M
21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1947 to Feb. 26, 1948 and that I last saw her alive on 2/21, 1948

Immediate cause of death: Arteriosclerotic Cardio-Vascular Disease — Duration: Several years
Due to:
Due to:
Other Conditions: Myocardial Failure — several months
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. A. Hoffman M. D.
Address 1109 N. Calvert Date signed 2/26/48

VS 150

X

660692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 171a

660692 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore & Asquith Sts.
(c) Hospital or institution: Mercy Hospital 6 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 129 N. Collington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie ROBENBLOOM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Poland (town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Poland

MOTHER
14. Maiden Name Not Known
15. Birthplace Poland

16 (a) Informant Max Bacha
(b) Address 129 No Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-29-48 (month) (day) (year)
(c) Cemetery or crematory Lonedale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jos Lewis Inc
(b) Address 2100 Eastern Place

19 (a) 2 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26, 1948 at 8:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection and Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture and dislocation of neck.

~~Other Conditions~~ Fracture of facial bones.
Lacerations of scalp and hip.
Fracture of both arms.
Fractures of ribs.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 5/1

(a) Date of injury Feb. 26, 1948 at 8:15 P.M.
(b) Where did injury occur? Balto. & Asquith Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Street Corner While at work? No
(d) Means of injury Struck by streetcar #14

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 2/26/48

VS. 151

G60693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G60693 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1803 N.Regester Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 N.Regester Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John F.Seeberger Sr.

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 213-03-3119

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Barbara A.Schlee

6 (c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Nov.27,1873

8. AGE: Years: 74 | Months: 3 | Days: 0 | If less than one day: ########## min.

9. Birthplace: Baltimore,Md.
(Town, county, and state)

10. Usual Occupation: Night-watchman

11. Industry or business

FATHER
12. Name: Michael L.Seeberger
13. Birthplace: Germany

MOTHER
14. Maiden Name: Mary ?
15. Birthplace: Germany

16 (a) Informant: John F.Seeberger Jr.(Son)
(b) Address: 3027 Northern Parkway,Balto:Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: March 1,1948 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd.Balto:Md.

18 (a) Funeral director: George J.Ruth,Inc.
(b) Address: 1735 Harford Avenue

19 (a) FEB 29 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb.27th., 1948, at 9 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/12 1947 to Feb 27 1948.
and that I last saw h/m alive on 2/22 1948.

Immediate cause of death: Coronary occlusion

Due to: Arteriosclerosis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Conrad L Richter M.D.
Address 1706 N Ward St. Date signed 2/28/48

V S 150

Huntington Williams, M.D.

Richter x

G60694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G60694 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1925 Sherwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1925 Sherwood Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Benjamin F.T.Leach

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 218-03-4378

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Mary L.Clark
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Jan.24,1883

8. AGE: Years	Months	Days	If less than one day
65	I	2	########## min.

9. Birthplace Baltimore,Md. (Town, county, and state)
10. Usual Occupation Auto Painter
11. Industry or business

FATHER
12. Name Benjamin F.Leach
13. Birthplace Maryland

MOTHER
14. Maiden Name Cantwell
15. Birthplace Maryland

16 (a) Informant William F.Leach
(b) Address 3325 Noble Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location 1001 Greenmount Avenue,Balto:Md.

18 (a) Funeral director George J.Ruth,Inc.
(b) Address 1735 Harford Avenue

19 (a) 2/29/48 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb.26th 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 1948 to Feb 26 1948, and that I last saw h[illegible] alive on Feb 24 1948

Immediate cause of death	Duration
Coronary Thrombosis	4 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S.L. Smith M.D.
Address 1223 E Nork Date signed 2/27/48

V S 150

X

660695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

660695 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 126 N. Streeper St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 126 N. Streeper St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Philip Salomon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna Salomon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1882

8. AGE: Years 65 | Months 7 4 | Days 27 | If less than one day hr. min.

9. Birthplace Germany.
(Town, county and state)

10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Peter Salomon
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine
15. Birthplace Germany.

16 (a) Informant Anita Salomon
(b) Address 126 N. Streeper St

17 (a) Burial (b) Date thereof 3-1-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director John J. Moran
(b) Address 3080 E. Balt. St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1948 at 1 20 X M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1947 to Feb 26 1948
and that I last saw alive on Feb 26 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	Feb 2 3 48
Due to Hemiplegia	Feb 19 48
Due to Arteriosclerosis	1946
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Grauer M. D.
Address 8012 Belford Ave Date signed 2/27/48

VS 190

X

660696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660696

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or institution: St. Josephs Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days

(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Prince George

(c) City or town Baltaville Baltsville

(If outside city or town limits, write RURAL and give town)

(d) Street No. Annandale Inst.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Brother Dorotheus (O'Brien)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-20-1867

8. AGE: Years 80 | Months 8 | Days 9 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Brother James

(b) Address Annandale Inst.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/48 (month) (day) (year)

(c) Cemetery or crematory Annandale

Location Annandale Md

18 (a) Funeral director

(b) Address

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/29 1948 at 10 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16 1948 to 2-29 1948 and that I last saw him alive on 2-29 1948

Immediate cause of death ARTERIOSCLEROTIC HEART DISEASE

Due to WITH CONGESTIVE HEART FAILURE

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Robert E May M. D.

Address 1400 N Caroline St Date signed 2-29-48

VS 150

660697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

660697 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3038 Remington ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3038 Remington ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME THOMAS J. FINN

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 215-10-1120

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife: Catherine Norton Finn
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1884

8. AGE: Years	Months	Days	If less than one day
63	5	22	..... hr. ..... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business

FATHER
12. Name Thomas Finn
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Curran
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Catherine Norton Finn
(b) Address 3038 Remington ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans & Son
(b) Address 118 W. Mt. Royal Ave

19 (a) FEB 29 1948 (Date rec'd by registrar) (b) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27 1948, at ..... M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1 1948 to Feb 27 1948, and that I last saw him alive on 2/26 1948

Immediate cause of death: Thrombosis-coronary — Duration —
Due to Hemiplegia — Duration 3 W 2 Hr.
Due to Arteriosclerosis
Other Conditions: Contracture leg + arm
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 2020 N. Charles Date signed 3/2/48

VS 150

G60698

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G60698 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2712 Whitney ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Mount Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 2712 Whitney ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** DELIA L. CORCORAN

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Single

6 (b) Name of husband or wife ---

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 1854 ?

8. AGE: Years	Months	Days	If less than one day
94 ?	—	—	..... hr. ..... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Stephen Corcoran
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Cuff
15. Birthplace Ireland

16 (a) Informant Miss Mollie Corcoran
(b) Address 2712 Whitney ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof MARCH 1-1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Cross Son Inc
(b) Address 119 N. Mt. Royal Ave

19 (a) ..... (b) ..... (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26 1948, at 4P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Feb 26 1948, and that I last saw her alive on Feb 26 1948.

Immediate cause of death	Duration
Acute Coronary Occlusion	—
Due to Coronary Sclerosis	years
Due to	
Other Conditions Varicose Veins	years

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Mendelis M. D.
Address 651 N Bentalou Date signed 2/28/48

VS 150

X

G60699 Aster-6

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

Registered No. 217948

G60699

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland ✓

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Georgia (b) County

(c) City or town Charlotte (If outside city or town limits, write RURAL and give town)

(d) Street No. 2236 Crescent Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Roy Ledford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Nannie Sue Ledford

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) 3-16-08

8. AGE: Years	Months	Days	If less than one day
39 years	11	10	..... hr. ..... min.

9. Birthplace Georgia (Town, county and state)

10. Usual Occupation Of R. R. Freight Agent

11. Industry or business

FATHER 12. Name Robert A. Ledford

13. Birthplace Georgia

MOTHER 14. Maiden Name Georgia Thomas

15. Birthplace Georgia

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-29-48 (month) (day) (year)

(c) Cemetery or crematory

Location Charlotte, N. C.

18 (a) Funeral director Lyon & Turner & Co.

(b) Address 127 E. 7th St. Pomona Terr.

19 (a) MAR 1 - 1948 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-28 1948, at 9 05 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-3 1948, to 2-28 1948, and that I last saw him alive on 2-28 1948.

Immediate cause of death: Bleeding Esophageal Varices

Due to Cirrhosis of the Liver

Due to Wilson's Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
10 yr

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Roger E Leonard

Address Johns Hopkins Hosp Date signed 2-29-48

VS 150

G60700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. G60700

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3607 MOHAWK AVE
(c) Hospital or institution: 28-T
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3607 MOHAWK AVE (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country —

3 (a) FULL NAME HARVEY E. LYONS

3 (b) If veteran, name war NONE

3 (c) Social Security Account No. NONE

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife EVELYN TIMANUS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 18, 1876

8. AGE: Years 71 | Months 11 | Days 9 | If less than one day hr. min.

9. Birthplace KLINES GROVE, PA. (Town, county, and state)

10. Usual Occupation RETIRED GOV'T INSPECTOR

11. Industry or business —

FATHER
12. Name DANIAL LYONS
13. Birthplace PA.

MOTHER
14. Maiden Name ELLEN CONRAD
15. Birthplace PA.

16 (a) Informant MR. HARVEY E. LYONS
(b) Address 3607 MOHAWK AVE

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 3/29/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ SUNBURY, PA.
Location

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTIMORE, MD.

19 (a) MAR 1 1948 (Date received by registrar) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/27/1948, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24 1948, to Feb 27 1948, and that I last saw h[illegible] alive on Feb 26 1948.

Immediate cause of death
Coronary Embolism
Mitral Regurgitation
Due to Arteriosclerosis
Hypertension
Due to [illegible]

Other Conditions Gen Osteo Arthritis (R. leg.)

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

Duration
1 hour
ad.
4 d
2 da
6 d.
46 yr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos F A Stevens M. D.
Address 2878 Hartford Rd Date signed 2-28-48

VS 150

X

G60701 6

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. G60701

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24-4
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 Bird Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James W. Bankowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lillian Moran

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1904

8. AGE: Years	Months	Days	If less than one day
44	1	1	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Driller

11. Industry or business Md. Drydock Manfg.

FATHER 12. Name W. Ladyslaw Bankowski

13. Birthplace Poland

MOTHER 14. Maiden Name Eleanor Jarock

15. Birthplace Poland

16 (a) Informant Mrs. Lillian Bankowski

(b) Address 1707 Byrd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-1-48 (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cem

Location Ritchie Highway

18 (a) Funeral director John F. Weber

(b) Address 401 S. Chester Street

19 (a) MAR 1 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-26 1948 at 5 05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Doa death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute dilatation and hypertrophy of heart, Acute pulmonary

Due to edema, and congestion of liver and all other

Other Conditions organs

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Uhlein M.D. Medical Examiner.

Date signed 2-26-48

VS 151

G60702 FL - 117471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH.

V 13B

Registered No. G60702

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 17-2
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 Brewer St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Almena Burroughs

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1926

8. AGE: Years	Months	Days	If less than one day
21	3	-	hr. min.

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jeff Burroughs
13. Birthplace S. C.

MOTHER
14. Maiden Name Anna ?
15. Birthplace

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/2/48 (month) (day) (year)
(c) Cemetery or crematory Dillion S. C.
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

19 (a) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24 1948, at 12.15 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 15 1948 to Feb. 24 1948. and that I last saw her alive on Feb. 24 1948.

Immediate cause of death	Duration
Pulmonary tuberculosis advanced	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Done

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. T. Bamford M. D.
Address Balt. City Hosp. Date signed 2-25-48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

60703 VANEY

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. 60703

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27-N. Carey St.
(c) Hospital or institution: 18-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name)
(d) Street No. 27-N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nancy Lee Wall.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30 1925

8. AGE: Years 22 | Months 8 | Days 27 | If less than one day hr. min.

9. Birthplace S. C. Florence (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Green Wall
13. Birthplace N. C.

MOTHER
14. Maiden Name Rachel Caraway
15. Birthplace N. Carolina

16 (a) Informant General McNeal
(b) Address 526-N. Carolina St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/2/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Edmondson Ave.

19 (a) MAR 1 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-26- 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1948 to Feb 26 1948 and that I last saw h. alive on Feb 26 1948.

Immediate cause of death Carcinoma of Rectum — Duration 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Italo Dompreia
Address 1348 Block St. Date signed 2/27/48 M. D.

VS 150

Washington Hill, M.D.

Italo Dompreia X

G60704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

Registered No. G60704

GM. 37777

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals 26-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. NO HOme (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hezekiah Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	W

6 (b) Name of husband or wife Maria (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13 -1867

8. AGE: Years	Months	Days	If less than one day
80	4	18	hr. min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Sally Baker
15. Birthplace N.C.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School FEB 20 1948
Location Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) MAR 1 - 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 1 - 1948, at 11.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 - 7 - 1938, to 2 - 1 - 1948, and that I last saw him alive on 2 -1 -48 1948.

Immediate cause of death	Duration
Pulmonary Edema	minutes
Due to Myocardial failure	minutes
Due to Ca of colon, duct C	months
Other Conditions Obstructive Jaundice	

(Include pregnancy within 3 months of death)

Date of operation 1-31-48
Major findings of operation: Ca of common bile duct
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 4940 Eastern Ave Date signed 2-18-48

X

G60705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G60705

GM. 117092

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 18-2
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 27 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27 -1861

8. AGE: Years 86 | Months 1 | Days 13 | If less than one day hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Johnson
13. Birthplace MD.

MOTHER
14. Maiden Name Alice Johnson
15. Birthplace MD.

16 (a) Informant Records Baltimore Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 20 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAR 1 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 9 - 1948, at 6.45A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 - 31-1948 to 2 - 9 -1948. and that I last saw him alive on 2- 9 - 1948.

Immediate cause of death Bronchopneumonia — Duration

Due to — Duration

Due to — Duration

Other Conditions Arteriosclerosis a Benigne. Fract. tibia left (Include pregnancy within 3 months of death) — Duration

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. B. Stewart M. D.
Address Baltimore City Hosp Date signed 3/18/48

VS 150

107

660706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30 D

Registered No. 660706

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3-2
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 WATSON ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: William H. Watkins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state) Baltimore

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Unknown

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School FEB 20 1948

18 (a) Funeral director Commissioner of Health

(b) Address Huntington Williams, M.D.

19 (a) MAR 1 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-12-1948 at 12 15 P M

21. I certify that I took charge of the remains described above, held an Autopsy & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Syphilitic aortitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George G. Morrill M.D. Medical Examiner.

Date signed 2-13-48

VS 151

660707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77c

G60707 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24-3
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LEROY WHITE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 63 | Months | Days | If less than one day ....hr. ....min.

9. Birthplace (Town, county, and state) Baltimore

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) **(b) Date thereof** (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School FEB 20 1948

18 (a) Funeral director Commissioner of Health
(b) Address

FEB 1 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2, 1948, at 6.55 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ....M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl V. Ryder M.D. Medical Examiner
Date signed 2-3-48

VS 181

G60708

AB-110649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

(1937)

Registered No. G60708

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 520 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Herling

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4- 1874

8. AGE: Years	Months	Days	If less than one day
73	4	-	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Herling (D
13. Birthplace Germany

MOTHER
14. Maiden Name Agnes Schubert
15. Birthplace Germany

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 24 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 1 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION AM

20. DATE OF DEATH Feb. 4- 1948 at 12.10M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-14 1947 to 2-4- 1948, and that I last saw him alive on 2-4- 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic heart disease	
Due to Generalized Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. T. Binford M. D.
Address Balt. City Hosp Date signed 2-18-48

VS 150

X

660709 tm. 114987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registered No. 660709

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 17 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Crownsville State Hospitals
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Parker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
? 66 ?			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name

13. Birthplace

MOTHER
14. Maiden Name

15. Birthplace

16 (a) Informant Baltimore City Hospitals
(b) Address Rukkin 4940 Eastern Ave (Records

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 24 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 1 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21/1948 19 , at 2.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 4 19 47 to Jan. 21 19 48 and that I last saw him alive on Jan. 21/1948

Immediate cause of death Iron Carcinoma, Lymphadenitis — Duration 5

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William M. Straight M. D.
Address BCH Date signed 2/18/48

VS 150

C60710 JL - 20126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45B

C60710

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 26-9
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 416 S. Conkling St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Boag or Henry Boag

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1872

8. AGE: Years	Months	Days	If less than one day
75	5	17	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business

FATHER
12. Name John
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Trimble
15. Birthplace Ireland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Locality Johns Hopkins Medical School FEB 24 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 1 - 1948 (Date rec'd by registrar) (Signature) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18 1948, at 3.05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 7 1937, to Jan. 18 1948, and that I last saw h im alive on Jan. 18 1948.

Immediate cause of death	Duration
Mob. Coronary Thrombosis	1 hr.
Due to Art. Scl. & Hypertensive C-V disease	10 yrs.
Due to	
Other Conditions Carcinoma base of tongue	

(Include pregnancy within 3 months of death)

Date of operation 1/13/48
Major findings of operation: Elective section 4/5th & 9th nerves, rt., for pain.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. M. N. Crosby M.D.
Address Balto. City Hosp. Date signed 1/20/48

VS 190

660711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160c

Registered No. 660711

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene Street
(c) Hospital or institution: University Md. Hospital Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3hrs. 45 Min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route #2
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Williams

3 (b) If veteran, name war

5 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M/C	WH. TC	Premature

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-16-48

8. AGE: Years	Months	Days	If less than one day
0	0	0	3 hr. 45 min.

9. Birthplace University Md. Hospital (Town, county, and state)

10. Usual Occupation Premature Infant.

11. Industry or business

FATHER
12. Name Elmer Carson Williams
13. Birthplace Clinchport, Va.

MOTHER
14. Maiden Name Venita Mae Barrette
15. Birthplace Clinchport, Va.

16 (a) Informant Mother
(b) Address Ellicott City Route #2, Md.

17 (a) Burial, cremation, or removal (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

(Location) Johns Hopkins Medical School FEB 24 1948

18 (a) Funeral director Commissioner of Health

(b) Address

MAR 1 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1948 at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1948 to Feb 16 1948 and that I last saw him alive on Feb 16 1948

Immediate cause of death	Duration
Cerebral Anoxia	
Due to Fetal Atelectasis	
Due to Prematurity	
Other Conditions Premature Rupture of membranes	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. C. Cooper, M.D.

Address University Md. Hospital Date signed 2-16-48

Redwood & Greene Streets Baltimore, Md.

VS 150

060712 SC-48-04441 X 157E 060712

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 060712

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Greene Streets
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 15/60 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 15/60 hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore Howard
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Cockeysville (Howard)
(If rural give location)
(e) Citizen of foreign country? Md (Yes or No)
If yes, name country

3 (a) FULL NAME Baby girl Sands

3 (b) If veteran, name war: —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	—

6 (b) Name of husband or wife: —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2/13/48

8. AGE: Years	Months	Days	If less than one day
			6 hr. 15 min.

9. Birthplace Baltimore, Baltimore, Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name James Stanley Sands
13. Birthplace

MOTHER
14. Maiden Name Rosa Holland
15. Birthplace Md.

16 (a) Informant Rosa Sands
(b) Address

17 (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School FEB 24 1948
Location Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) [illegible] (Signature of registrar) (b) Huntington Williams, M.D. Registrar

VS 180-

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/14/48 1948, 12:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 13 1948 to Feb. 14 1948, and that I last saw h[illegible] alive on Feb. 13 1948.

Immediate cause of death	Duration
Cardio-Resp. Failure	
Due to Fetal atelectasis	
Due to Congenital Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wachael Galambos M. D.
Address University Hosp Date signed 2-20-48

X

C60713

BC-48-04206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. C60713

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) ~~Same~~ Hospital for Women of Md

(c) Hospital or institution: 9-40

(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 min

(e) Length of stay in Baltimore (yrs., mos., or days) 30 min

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore 18 (If outside city or town limits, write RURAL and give town)

(d) Street No. 3041 Matthews St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Daniel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day hr. 30 min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER

12. Name Charles Franklin Daniel

13. Birthplace Balto. Md

MOTHER

14. Maiden Name Elizabeth Ruth Norris

15. Birthplace Balto Md

16 (a) Informant Mrs. Charles F. Daniel

(b) Address 3041 Matthews St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical School FEB 24 1948

18 (a) Funeral director Commissioner of Health

(b) Address

MAR 1 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1948 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 22 1948 to Feb 22 1948, and that I last saw him alive on Feb 22 1948.

Immediate cause of death Atelectasis — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature U. C. Riley M. D.

Address Woman's Hospital Date signed 2-23-48

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

660714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 457

Registered No. 660714

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23-V
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1406 Light Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT F. JENKINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married

6 (b) Name of ~~husband or~~ wife Mary M. Jenkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 79 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Laborer

FATHER
12. Name Frederick Jenkins
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Wm O. Miller
(b) Address 713 Wilbron Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/2/48 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) MAR 1 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/28/48 19 , at 11:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma Mandible

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 2/28/48

X

Kuskey

BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G60715

G60715

CERTIFICATE OF DEATH 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — D. 1st
(b) Street address
(c) Hospital or institution: Mercy Hospital 7-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1638 Abbott St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Milton Kuskey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1892

8. AGE: Years	Months	Days	If less than one day
55	8	28	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Baker
11. Industry or business Both. Steel Co.

FATHER
12. Name William Kuskey
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Offendorf
15. Birthplace Maryland

16 (a) Informant Wm. Kuskey
(b) Address 1638 Abbott Street

17 (a) Burial (Burial, ~~cremation,~~ or removal) (b) Date thereof 3/1/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto Md.
Location

18 (a) Funeral director Williams Dok Inc.
(b) Address 127 E. Pleasant St.

19 (a) MAR 1 - 1948 (Date rec'd by registrar) (b) Certificate for Williams

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/29 1948, at 1:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed 2/29/48

G60716 Aber. 6

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. 44168

G60716

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 12-2
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3135 Abell ave (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country Ireland

3 (a) FULL NAME Richard Newell
3 (b) If veteran, name war
3 (c) Social Security Account No. 218-03-1300

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Emma Newell
6 (c) If alive, give age 64 years
7. Birth date of deceased (mo., day, yr.) 4-23-83

8. AGE: Years	Months	Days	If less than one day
64 years	10	5	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name John Newell
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Trotter
15. Birthplace Ireland

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) MAR 1 - 1948 (Date rec'd by registrar) (b) Interior for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-28 1948, at 10.00 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-31 1948 to 2-28 1948 and that I last saw him alive on 2-28 1948

Immediate cause of death Cancer of lung — Duration 6 mos
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dayton H. Coutts
Address Johns Hopkins Hosp Date signed 2-29-48

VS 150

X

660717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 660717

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 214 S. PAYSON ST.
(c) Hospital or institution: 20-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 214 S. PAYSON ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY T. MILLER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOWED

6 (b) Name of husband ~~or wife~~ Late JOHN B
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 17, 1870

8. AGE: Years	Months	Days	If less than one day
77	11	10	hr. min.

9. Birthplace BALTIMORE, MD (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name ANTHONY SCHALITZKY
13. Birthplace BALTO. MD

MOTHER 14. Maiden Name
15. Birthplace BALTO. MD

16 (a) Informant MR EDWARD A MILLER
(b) Address 214 S PAYSON ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MARCH 1 1948 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location OLD FREDERICK RD

18 (a) Funeral director Harry H Wiltse
(b) Address 4101 Edmondson Ave

19 (a) MAR 1 - 1948 (Date rec'd by Registrar) (b) Burington Wilmington

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1948 at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1948 to Feb 27 1948 and that I last saw h[illegible] alive on Feb 26 1948.

Immediate cause of death	Duration
Respiratory Failure	
Due to Coronary occlusion	
Due to Hypertensive Cardio-vascular renal disease	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Aborofsky M.D.
M. D.
Address 601 N. Howard St Date signed 2/27/48

VS 150

X

G60718 .

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G60718

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2105 Boone St.
(c) Hospital or institution: 9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2105 Boone St. (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore, Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Jane Eppee

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Martin Eppee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years	Months	Days	If less than one day
84	3	—	hr. min.

9. Birthplace Ireland - (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Thomas Clark -
13. Birthplace Ireland -

MOTHER
14. Maiden Name Mary Barrett
15 Birthplace Ireland

16 (a) Informant Mrs. Mary Dempsey
(b) Address 2105 Boone St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-1-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location City

18 (a) Funeral director Wiedefeld & Son
(b) Address Greenmount & 22nd St.

MAR 1 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26th 1948, at 1.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1947 to 26 Feb 1948 and that I last saw her alive on 24 Feb 1948

Immediate cause of death: Arteriosclerotic Cardio-Vascular Disease — Duration: 10 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. H. Kammer, Jr.
Address 501 Sheridan Ave Date signed 2 Mar 48

VS 150

X

G60719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G60719

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ✓
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: The Seton Institute
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-6-29
(e) Length of stay in Baltimore (yrs., mos., or days) 17yrs. 1mo. 29 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pennsylvania (b) County
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)
(d) Street No. St. Vincents Cemetery Chelten Ave., Germantown, Pa. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Reverend John V. Judge, C.M.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-22-98

8. AGE: Years	Months	Days	If less than one day
49	6	7	hr. min.

9. Birthplace Brooklyn, New York (Town, county, and state)

10. Usual Occupation Catholic priest

11. Industry or business

FATHER 12. Name John P. Judge

13. Birthplace Ireland

MOTHER 14. Maiden Name Ellen Kelly

15. Birthplace Ireland

16 (a) Informant The Setony Institute

(b) Address 6420 Reisterstown Road, Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-1-48 (month) (day) (year)

(c) Cemetery or Crematory Loyolaress

Location Brooklyn, N.Y.

18 (a) Funeral director Lawson Mortuary Co.

(b) Address 1020 N. Howard St.

19 (a) MAR 1 - 1948 (Date rec'd by registrar) (b) Registrar for Williams

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-29 1948, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1930, to Feb 26 1948, and that I last saw him alive on Feb. 26 1948.

Immediate cause of death: Coronary occlusion — Duration: 3 days

Due to

Due to

Other Conditions: schizophrenia paranoid type
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Damian P. Hegan M. D.

Address 33 W. Preston St. Date signed

460720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. 460720

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland 12-3

(b) Street address Linden Ave. & Madison Street

(c) Hospital or institution:
Maryland General Hospital
(Improvide)

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-24-X

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) ~~County~~ Baltimore City

(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)

(d) Street No. 301 Whitridge Avenue
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie McWhirter Wallace

3 (b) If veteran, name war: None

3 (c) Social Security Account No. ~~None~~ ?

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Joseph E. Wallace

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept-6-1881

8. AGE: Years 66 | Months 5 | Days 21 | If less than one day: ____ hr. ____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name William McWhirter
13. Birthplace Maryland

MOTHER
14. Maiden Name Jane Connor
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Emerson Spedden (cousin)
(b) Address 911 E. Belvedere Ave., City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar-2-1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Baltimore (23)

18 (a) Funeral director Stewart & Mowen Company

(b) Address 108 W. North Avenue, City #1.

19 (a) MAR 1 - 1948 (Date rec'd by registrar) (b) Permit for Williams [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-24 1948, at 3 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-24 1948 to 2-25 1948 and that I last saw h[illegible] alive on 2-25 1948.

	Duration
Immediate cause of death [illegible] from	
Due to generalized Carcinomatosis	
Due to primary site of Carcinoma not found	
Other Conditions pathological fracture of left femur	1-27-48

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: 2-27-48 - generalized [illegible] Carcinomatosis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ____ at ____ M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Eugene A Patonelli M.D.

Address [illegible] Date signed 2-27-48

Patonelli X

VS 150

660721

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 52B

Registered No. 660721

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St.
(c) Hospital or institution: Good Samaritan Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Edgemere (If outside city or town limits, write RURAL and give town)
(d) Street No. 6908 River Drive Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William H. Hughes
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Alice M. Hughes
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) January 10, 1870
8. AGE: Years 78 Months 1 Days 17 If less than one day hr. min.
9. Birthplace Baltimore Co., Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Police Dept.
FATHER 12. Name William H. Hughes
FATHER 13. Birthplace Balto. Co., Md.
MOTHER 14. Maiden Name Mary E. Nices
MOTHER 15. Birthplace Md.
16 (a) Informant Mrs. Alice M. Hughes
16 (b) Address 6908 River Drive Rd. Sparrows Point
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 1, 1948 (month) (day) (year)
17 (c) Cemetery or crematory Oaklawn
Location Balto. Co., Md.
18 (a) Funeral director Roland L. Fisher
18 (b) Address 2112 Dundalk Ave.
19 MAR 1 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Feb 1948, at 1 M
21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1948 to Feb 27 1948 and that I last saw h[illegible] alive on Feb 27 1948.

Immediate cause of death	Duration
Carcinoma of Bladder	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [illegible] M. D.
Address 1348 Blank St Date signed 27 Feb 1948

VS 150

Stello IMPrec19 X

G60722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G60722

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16-7
(c) Hospital or institution Walt Balt. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2931 Presstman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME (William Huber) George W. Haubner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife May Bessie Haubner
6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) 7/13/1879 1879

8. AGE: Years	Months	Days	If less than one day
68	7	16	hr. min.

9. Birthplace Hoboken - New Jersey (Town, County, and State)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name George Haubner
13. Birthplace Germany

MOTHER
14. Maiden Name Josephine Kretzer
15. Birthplace New York

16 (a) Informant Boya Funeral Home
(b) Address Harristown, Pa.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/1/48 (month) (day) (year)
(c) Cemetery or crematory Ger. Washington Mem.
Location Harristown Pa.

18 (a) Funeral director Wellborn Cook Inc
(b) Address 1217 St Paul St

19 (a) MAR 1 - 1948 (Date rec'd by registrar) (b) Interment for Willie [illegible]

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Feb 1948, at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy + Insp. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L Rogers M.D. Medical Examiner
Date signed 29 Feb 48

C60723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/186a

Registered No. C60723

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 25-3

(a) Baltimore City, Maryland

(b) Street address Wilkens & Caton Avenue

(c) Hospital or institution:

St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9

(e) Length of stay in Baltimore (yrs., mos., or days) 76

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 1919 N. Brentwood Ave. (If rural give location)

(e) Citizen of foreign country? Na. (Yes or No)

If yes, name country

3 (a) FULL NAME Mary Carrie Debus (DEBUS)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Married

6 (b) Name of husband or wife Andrew Debus

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1871?

8. AGE: Years	Months	Days	If less than one day
76	7	14	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Michael Sonnenleiter

13. Birthplace Germany

MOTHER

14. Maiden Name Elizabeth

15. Birthplace Germany

16 (a) Informant Andrew D. Debus

(b) Address 1919 Brentwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/2-48 (month) (day) (year)

(c) Cemetery or crematory Westlawn

Location Edmondson Ave

18 (a) Funeral director Edward Foulson

(b) Address 2359 Work Place

MAR 3 1948 (Date rec'd) (b) Funeting for Williams, M.D. Registrar

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28, 1948, at 8.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw her alive on Feb. 28 1948.

Immediate cause of death Pulmonary atelectasis

Due to Respiratory Failure

Due to Cardio-vascular & respiratory collapse

Other Conditions Fractured neck of femur left (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Accident 25/3 M

(b) Date of occurrence approx 2-14-48

(c) Where did injury occur? 1919 N. Brentwood Ave (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No

(e) Means of injury Slipped & fell to floor

23. Signature Walter J. Eckhardt Coroner

Address St. Agnes Hospital Date signed 2/28/48

John R. Davis MD per Gh Merrill MD X

G60724

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

54B

Registered No. G60724

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital 26-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore # 24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 910 S. Conkling St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William V. Mullaney

3 (b) If veteran, name war —

3 (c) Social Security Account No. 219-01-8787

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Wilhelmina Mullaney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1884

8. AGE: Years 63 | Months 3 | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James Mullaney
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Maryland

16 (a) Informant James Mullaney (Son)
(b) Address 910 S. Conkling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 2, 48 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus Cem
Location Dundalk Ave. Balto. Md.

18 (a) Funeral director Charles S. Zeller
(b) Address 901 S. Conkling St.

19 (a) Date rec'd by Registrar MAR 1 1948 (b) Registrar Kathryn Williams, Mrs.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1948, at 4:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-23 1948, to 2-28 1948, and that I last saw him alive on 2-28 1948.

Immediate cause of death	Duration
Due to Cerebral neoplasm	over 1 mo.
Due to	
Other Conditions	over

(Include pregnancy within 3 months of death)

Date of operation 2-24-48

Major findings of operation: Inoperable tumor, rt. parietal lobe.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert J. Johnson M. D.
Address Mercy Hospital Date signed 2-29-48

X

660725 Golly

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 660725

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5101 Harford Road
(c) Hospital or institution: 27-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5101 Harford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth R. Schulz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
femle	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1886

8. AGE: Years	Months	Days	If less than one day
61	2 3	2 20	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John H. Schulz
13. Birthplace Md.

MOTHER
14. Maiden Name Mary List
15. Birthplace Md.

16 (a) Informant Mrs. John J. Geiss
(b) Address 5101 Harford Road, 14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road-14-

19 (a) MAR 1 - 1948 (Date rec'd by registrar) (b) Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27th, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 24 1948 to Feb 27 1948 and that I last saw h alive on 2/27 1948.

Immediate cause of death Acute Pulmonary Edema
Due to
Due to
Other Conditions Coronary Thrombosis

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 5103 Harford Rd Date signed 2/27/48

VS 150

110B

G60726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G60726 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2604 Roselawn Ave
(c) Hospital or institution: 27-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2604 Roselawn Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice C. Cox.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Wm. G. Cox
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26-1897

8. AGE: Years	Months	Days	If less than one day
55	9	2	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ✓ Locke
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Mrs. Wm. G. Cox
(b) Address 2604 Roselawn
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/2/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto
18 (a) Funeral director L. J. Leuck
(b) Address 5305 Harford Rd.
19 (a) MAR 1 1948 (Date rec'd by registrar) (b) Huntington Wills Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1948, at 5:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congestive Heart Failure

Due to A. S. C. V. Disease

Other Conditions Fracture of Rt. Ankle

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 13 Feb at 27/6 M.
(b) Where did injury occur? 2604 Roslawn Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Fell from standing position

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 29 Feb 48

VS 151

C60727

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 307

Registered No. C60727

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai 27-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5103 Sheldon Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Norah V. Hall

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M W

6 (b) Name of husband or wife Ernest E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25-1897

8. AGE: Years	Months	Days	If less than one day
55	✓	✓	hr. min.

9. Birthplace Balto, Md. (Town, county and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ✓ Clifford
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace

16 (a) Informant Mrs. Paul Zeller
(b) Address 20 Delight Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Pk.
Location Balto Co.

18 (a) Funeral director L. J. Luck
(b) Address 5345 Stafford Rd.

19 (a) MAR 1 - 1948 (Date rec'd by registrar) (b) Huntington Hill, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27 1948, at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 27 1948 to Feb. 27 1948, and that I last saw her alive on Feb. 27 1948.

Immediate cause of death	Duration
Ruptured dissecting aortic aneurysm	
Due to Hypertension and Cerebrovascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Ruptured aortic dissecting aneurysm

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice S. Eisenberg
Address Sinai Hospital Date signed 2/28/48 M D

X

G60728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G60728

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 607 Brantley St 16-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 607 Brantley St
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mary V. Brand

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1875

8. AGE: Years	Months	Days	If less than one day
72	3	—	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Gilchrist
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary McDermott
15. Birthplace Ireland

16 (a) Informant Margaret Seymour
(b) Address 607 Brantley St

17 (a) Burial (b) Date thereof 3-2-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Geo. A. Dorley
(b) Address Fulton Ave. & Fayette St

19 (a) MAR 1 - 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 1948, at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 21, 1948, to Feb 27 1948 and that I last saw h. alive on Feb 27 1948.

Immediate cause of death	Duration
Acute Cardiac Dilatation	1 day
Due to Hypertensive Cardiovascular disease	7
Due to	
Other Conditions Nephrosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Fury Glassman M. D.
Address 753 W. Fayette St Date signed Mar 1, 48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Register No. 60729

60729

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3943 Elm Ave
(c) Hospital or institution: 13-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3943 Elm Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ethel Vogelman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife John H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15 1895

8. AGE: Years	Months	Days	If less than one day
52	9	12	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Wm Ortel
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Smith
15. Birthplace Baltimore

16 (a) Informant Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/48 (month) (day) (year)
(c) Cemetery or ~~cemetery~~ Oaklawn
Location 7225 Eastern Ave

18 (a) Funeral director Clarence Hofmann
(b) Address 1639 N. Broadway

19 (a) MAR 1 1948 (Date rec'd by reg. registrar) (Signature of Registrar) Hunter-Lee Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/29 1948, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Valvular Heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature O. R. Sulemoka M.D. (Medical Examiner.)
Date signed 2/29/48

VS 151

X

060730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 155

Registered No. 060730

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 767 S. Grantley St.
(c) Hospital or institution: 16-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 767 S. Grantley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cecilia D. Stapleton

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Thomas F. Stapleton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1st 1887

8. AGE: Years	Months	Days	If less than one day
60	10	27	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation House Work
11. Industry or business at Home

FATHER
12. Name Thomas F Cannon
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Headley
15. Birthplace Ireland

16 (a) Informant Mrs Angela Hewitt
(b) Address 767 S Grantley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location 4302 Old Frederick Rd

18 (a) Funeral director John F Cannon & Son
(b) Address 401-03 W Hollins St

19 (a) FEB 1 1948 (Date received by Registrar) Theodora Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28th 1948, at 1 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946 to Feb 25 1948, and that I last saw h[illegible] alive on Feb 25 1948

Immediate cause of death	Duration
Acute myocardial failure	
Due to Arteriosclerosis resulting from Paget's Disease	over
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Cavalaher M. D.
Address 24 W Fulton Ave Date signed 2/28/48

VS 150

X

060731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46E

Registered No. 060731

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 15.11

(a) Baltimore City, Maryland

(b) Street address 3570 N Hilton

(c) Hospital or institution: Shriners Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 3 mo

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3570 Hilton Ln
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice R. Shriner

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Robert L. Shriner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30 1853

8. AGE: Years	Months	Days	If less than one day
94	0	26 27	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Retired Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant William R. Shriner

(b) Address 3570 N Hilton St

17 (a) Burial (b) Date thereof 3-1-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location Baltimore, Maryland

18 (a) Funeral director Loring Byers

(b) Address 5105 Park Heights Ave

19 (a) MAR 1 - 1948 (b) Katherine Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 1948 at 6 PM M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to Feb 26 1948, and that I last saw her alive on Feb 25 1948

Immediate cause of death	Duration
Carcinoma Lung	8 mo
Due to Lipoma	1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Ida Stevens M. D.

Address 787 Hanover St Date signed 2-28-48

V S 150

X

G60732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G60732

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2919 PRESBURY ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2919 PRESBURY ST. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME JOHN GERSTMYER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife KATIE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR 23, 1883

8. AGE: Years	Months	Days	If less than one day
64	11	4	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation LINEN THREAD Co.
11. Industry or business —

FATHER
12. Name LOUIS GERSTMYER
13. Birthplace GERMANY

MOTHER
14. Maiden Name SOPHIE BEILSTEIN
15. Birthplace GERMANY

16 (a) Informant MRS. KATIE GRISTMYER
(b) Address 2919 PRESBURY ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/1/48 (month) (day) (year)
(c) Cemetery or Crematory WESTERN
Location BALTIMORE, MD

18 (a) Funeral director WM. J. TICHNER & SONS
(b) Address BALTIMORE MD.

19 MAR 1 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/27 1948, at 1 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 17 1948 to Feb 27 1948 and that I last saw h[illegible] alive on Feb 25 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Pneumonia	10 days
Due to Renal Arteriosclerosis	✓
Other Conditions ✓	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: ✓
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at ✓ M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? ✓ (Specify type of place)
(e) Means of injury ✓

23. Signature Edward L. Tuohey M. D.
Address 19 Poplar Grove Date signed 3/2/48

48 189

G60733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

Registered No. G60733

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 730 GRANTLY ST.
(c) Hospital or institution: 16-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 730 GRANTLY ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNIE REBECCA WILEY

3 (b) If veteran, name war No | 3 (c) Social Security Account No. No

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. WIDOW

6 (b) Name of husband or wife THOMAS O. WILEY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/13/1862

8. AGE: Years 85 | Months 11 | Days 14 | If less than one day hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name GEORGE CATHCART
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name MARGARET DIVEN
15 Birthplace BALTIMORE, MD.

16 (a) Informant MR. EDWARD G. LONG
(b) Address 730 GRANTLY ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/1/48 (month) (day) (year)
(c) Cemetery or crematory WESTERN
Location BALTIMORE, MD.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address BALTIMORE, MD.

19 (a) MAR 1 1948 (Date rec'd by registrar) Huntington Williams Registrar
(b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/27/48 19— at 8 12 A M

21. I certify that death occurred on the date above stated; that I attended deceased from November 28 1947 to Feb 27 1948 and that I last saw h/er alive on Feb 27 1948

Immediate cause of death Myocarditis degeneration Cerebral arterio sclerosis type Heart disease Duration several years

Due to with hypostatic pneumonia and congestive failure

Due to generalized arterio sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Michel M. D.
Address 2901 Edmondson Ave Date signed Feb 28 48

X

660734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 660734

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1747 Cliftview Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1747 Cliftview Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country —

3 (a) FULL NAME: EMMA MAE TYLER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife GEO. H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUN. 17 1870

8. AGE: Years	Months	Days	If less than one day
77	8	10	hr. min.

9. Birthplace SOMERSET CO., MD. (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business —

FATHER
12. Name ROBERT HICKMAN
13. Birthplace MD.

MOTHER
14. Maiden Name CLEMENTINE JONES
15 Birthplace MD.

16 (a) Informant MRS. J. LEONARD HALL
(b) Address 3953 WILSBY ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/1/48 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE CEM.
Location BALTIMORE, MD.

18 (a) Funeral director WM. J. TICKNER & SONS.
(b) Address Balto MD.

19 (a) MAR 1 - 1948 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/27 1948, at 1 20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 18 Feb 1948 to 27 Feb 1948 and that I last saw her alive on 27 Feb 1948.

Duration

Immediate cause of death: Acute cardiac failure

Due to: Hypertension cardio-vascular disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John H. Barnaby M. D.
Address 1531 E. North Ave Date signed 2/28/48

G60735

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

G60735 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 N. Colvin
(c) Hospital or institution: 5-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 N. Colvin st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John H. Johnson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	Married

6 (b) Name of husband or wife Martha Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1849

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Johnson
13. Birthplace Va.

MOTHER
14. Maiden Name Dora Ridgely
15 Birthplace Va

16 (a) Informant Martha Johnson
(b) Address 405 Colvin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location

18 (a) Funeral director Elroy D. Watson
(b) Address 1000 Brantly Ave

19 MAR 1 - 1948 (Date rec'd by registrar) (b) Huntington Hillsboro, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/27 1948, at 9:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/16/1948 to 2/27 1948, and that I last saw h[illegible] alive on 2/26 1948.

Immediate cause of death	Duration
Pulmonary Tuberculosis	3-4 months
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A.H. Wenstock M. D.
Address 1403 Park Ave Date signed 2/27/48

VS 150

G60736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G60736 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT ST.
(c) Hospital or institution: MERCY HOSP. 27-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3104 CHESLEY AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FERDINAND MANN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1863

8. AGE: Years	Months	Days	If less than one day
85			hr. min.

9. Birthplace GERMANY (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name CASPER MANN
13. Birthplace GERMANY

MOTHER
14. Maiden Name ANN MOSCHEM
15 Birthplace GERMANY

16 (a) Informant ADM. SLIP.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 3 1948 (month) (day) (year)
(c) Cemetery or crematory Morelund Mem. Park
Location Taylor Ave

18 (a) Funeral director L. Heemann & Son
(b) Address 6067 Harford Rd. Huntingtown for Williamsport, Md.

19 (a) MAR 1 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/28 1948 at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/8 1948 to 2/28 1948 and that I last saw h.. M alive on 2/28 1948

Immediate cause of death CARDIO-RESP FAILURE — Duration

Due to ARTERIO-SCLEROSIS GENERALIZED

Due to BRONCHO PNEUMONIA

Other Conditions UREMIA SENILITY

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elden H. Pentz M. D.
Address MERCY HOSP Date signed 2/28/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 660737

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 216 Homberg Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis William Brehm

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-7646

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Anna L. (Brady)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5-1883

8. AGE: Years	Months	Days	If less than one day
64	5	22	hr. min.

9. Birthplace Balto Co. Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Brehm
13. Birthplace Balto

MOTHER
14. Maiden Name Janette Lawrence
15. Birthplace Balto Co. Md.

16 (a) Informant Mrs. Anna L. Brehm
(b) Address 216 Homberg Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-1-48 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location O'Donnell St Rd

18 (a) Funeral director John J. Connelly
(b) Address 418 Eastern Ave

19 (a) MAR 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27, 1948, at 7 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary thrombosis.
Myocardial infarction, with
Due to perforation of heart and
massive hemorrhage into
Other Conditions pericardial cavity.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Geo. G. Merrill M.D. Medical Examiner.
Date signed 2/27/48

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G60738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

133a

Registered No. G60738

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 8710 Wilson Ave. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Mary Blanche Willson

3 (b) If veteran, name war

3 (c) Social Security Account No. 578-24-5057

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Laurence E. Willson

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 3/2/1882

8. AGE: Years 45 | Months 11 | Days 17 | If less than one day ..... hr. ..... min.

9. Birthplace Caroline Co. Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Cyrus F. Collins
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mollie A. Engle
15. Birthplace Caroline Co. Md.

16 (a) Informant Laurence E Willson
(b) Address 8710 Wilson Ave

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof 3 4 48 (month) (day) (year)
(c) Cemetery or crematory.....
Location Fredericksburg Md.

18 (a) Funeral director Forsaith Funeral Home
(b) Address 7471 Belair Rd.

19 MAR 1 - 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 29 1948, at 11 30 PM

21. I certify that I took charge of the remains described above, held an Insp. & Insp. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to last death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH..... Acute pulmonary edema

Due to Hypertensive arterio-sclerosis

Other Conditions Chronic pyelo-nephritis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Chas. H. Rogers M.D. Medical Examiner.
Date signed 3-1-48

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G60739

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G60739

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 417 Tuxedo St
(c) Hospital or institution: 12-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 417 Tuxedo St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter C Dip

3 (b) If veteran, name war W | 3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Affair
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 4, 1872

8. AGE: Years 75 | Months 6 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Painter Retired

11. Industry or business

FATHER
12. Name Octavious Dip
13. Birthplace Md

MOTHER
14. Maiden Name Alice Knight
15. Birthplace Baltimore Co Md

16 (a) Informant Alice B Stiffler
(b) Address 417 Tuxedo St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/2/48 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Homeland Baltimore Co Md

18 (a) Funeral director Pikesville Funeral Home
(b) Address 1211 N Eutaw St

19 (a) MAR 1 1948 Registered by (Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 1948, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 25 1947 to Feb 28 1948 and that I last saw him alive on Feb 28 1948

	Duration
Immediate cause of death Congestive Heart Failure	Two weeks
Due to Arteriosclerotic Cardiovascular Disease	4 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Wallenstein M.D.
Address 848 W 36 St Date signed 3/1/48

VS 150

G60740 BC-48-0465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G60740

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 10-1

(a) Baltimore City, Maryland ✓

(b) Street address Calvert & Saratoga Sts

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1117 Wilcox St (If rural give location) Mercy Hospital

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Smoot

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: none

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1948

8. AGE: Years | Months | Days | If less than one day: 23 hr. ____ min.

9. Birthplace Mercy Baltimore, Md. (Town, county, and state)

10. Usual Occupation infant

11. Industry or business

FATHER 12. Name Charles Smoot

13. Birthplace Baltimore, Md Bankley

MOTHER 14. Maiden Name Magdalene H. Smoot

15. Birthplace Baltimore Md

16 (a) Informant ____

(b) Address ____

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Mar. 1, 1948 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cemetery

Location 4430 Belair Road

18 (a) Funeral director Elmer W. Coughlin & Son

(b) Address 924 E. Eager St.

MAR 1 - 1948 (Date rec'd by registrar) (b) Arlington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-28 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 27 1948 to Feb 28 1948 and that I last saw him alive on Feb 28, 1948.

Immediate cause of death	Duration
Premature birth — Gestation about 4½ mo.	
Due to unknown	
Due to unknown	
Other Conditions none	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: ____

of autopsy: ____

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide ____

(b) Date of occurrence ____ at M

(c) Where did injury occur? ____ (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)

(e) Means of injury ____

23. Signature D. Otis Montgomery M.D. M. D.

Address Feb. 28, 1948 Date signed Mercy Hospital

VS 150

A G60741 Dec per Baby

BALTIMORE CITY HEALTH DEPARTMENT ✓ Rev G60741

CERTIFICATE OF DEATH 94a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2408 McElderry St
(c) Hospital or institution: 7 2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2408 McElderry St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Varholy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John Varholy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15, 1868

8. AGE: Years	Months	Days	If less than one day
79	6	13 12	hr. min.

9. Birthplace Austria Hungary (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Michael Mikó
13. Birthplace Austria

MOTHER
14. Maiden Name Not known
15. Birthplace Austria

16 (a) Informant Joseph Varholy
(b) Address 2408 McElderry St

17 (a) Burial (Burial, cremation, or removal) (b) Date of [illegible] (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Frank Grachan
(b) Address 900 N Chester St

19 (a) [illegible] (Date received by registrar) (b) Washington Nilliams M.D.

MAR 1 1948

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1948, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24 1948 to Feb 27 1948.
and that I last saw her alive on Feb 27 1948

Immediate cause of death: Coronary Thrombosis — Duration: 3 days

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Pokorny M. D.
Address 2200 E Madison Date signed 2/28/48

X

C60742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 69

Registered No. C60742

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1204 Argyle ave
(c) Hospital or institution: 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 years

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 argyle ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Turner

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day
79			hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Gladys Thompson
(b) Address 1204 Argyle ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-3-48 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Balto md

18 (a) Funeral director George H. Kelson
(b) Address 1307 Pennsylvania Ave Huntington Williamsport, Md

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 1- 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 29 1948 at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16 1948, to 2-29 1948, and that I last saw h alive on 2-27 1948

Immediate cause of death	Duration
Cerebral hemorrhage	12 da.
Due to hypertension	4 yrs.
Due to	
Other Conditions pellagra	4 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. W. M Daniel M. D.

Address 817 N. Caroline Date signed 3-1 48

8-3a

G60743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G60743 Registered No.

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland 17-3

(b) Street address 818 Harlem ave

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 818 Harlem ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Turner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	c	married

6 (b) Name of husband or wife Catherine Turner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 27, 1888

8. AGE: Years	Months	Days	If less than one day
60	1	-	hr. min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER

12. Name John Turner

13. Birthplace md

MOTHER

14. Maiden Name —

15. Birthplace —

16 (a) Informant Catherine Turner

(b) Address 818 Harlem ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3-2-48 (month) (day) (year)

(c) Cemetery or crematory Western Star cem

Location md

18 (a) Funeral director George E. Kelson

(b) Address 1303 Pennsylvania Ave

19 (a) (Date rec'd by registrar) (b) Arthur Williams M.D. Registrar

3-1-1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27 1948, at 2:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-27 1948 to 2-27 1948, and that I last saw him alive on 2-27 1948.

Immediate cause of death	Duration
Cerebro Vascular Accident (Hemorrhage)	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Ben Gold M. D.

Address Date signed

X

G60744

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G60744
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 720 Mura St.
(c) Hospital or institution: 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 720 Mura Street
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Frances Parsons

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Edward L. Parsons
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Sept. 25, 1883
8. AGE: Years 64 | Months 8 | Days 4 | If less than one day: hr. min.
9. Birthplace Wicomico County, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name James Crouch
13. Birthplace Maryland

MOTHER
14. Maiden Name Louisa Taylor
15. Birthplace Maryland

16 (a) Informant George H. Parsons.
(b) Address 720 Mura St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-3-48 (month) (day) (year)
(c) Cemetery or crematory Shad Point
Location Wicomico County, Md.

18 (a) Funeral director Holloway & Co
(b) Address Salisbury, Maryland

19 (a) MAR 1 - 1948 (Date rec'd by registrar) (b) Lexington Williams, M.D. Registrar

VERIFIED MAR 1

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Feb. 1948, at 6:05 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to Hypertensive Cardio-Vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Tomme, Jr., M.D. Medical Examiner.
Date signed 27 Feb 48

G60745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

G60745 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Ellicott
(If outside city or town limits, write RURAL and give town)
(d) Street No. St. Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel BROWN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/5/1860

8. AGE: Years	Months	Days	If less than one day
68	8	24	hr. min.

9. Birthplace Balto Co Md
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John R. Brown
13. Birthplace unknown

MOTHER
14. Maiden Name Alverta Stultz
15. Birthplace unknown

16 (a) Informant George Brown
(b) Address Ellicott City, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-3-48 (month) (day) (year)
(c) Cemetery or crematory St Johns
Location Howard Co. Md

18 (a) Funeral director F C Higinbotham
(b) Address Ellicott City, Md

19 (a) MAR 1 1948 (Date rec'd by registrar) (b) Courtenay Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 29 1948, at 10 50 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma of bladder

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 3/1/48

VS 151

G60746

3C-48-0451K

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

160a

G60746
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The street age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's 26-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4412 Kavon Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wysocki, Baby Boy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1948

8. AGE: Years | Months | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Wysocki, Edward Michael

13. Birthplace Balto., Md.

14. Maiden Name Tress, Virginia Ella

15. Birthplace Balto., Md.

16. (a) Informant Mother (Virginia Ella Wysocki)

(b) Address 4412 Kavon Ave., Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-1-48 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Taylor ave Parkville

18 (a) Funeral director Hease & Weber

(b) Address 701 E. 33rd St

19 (a) (Date received by local registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1, 1948 19 , at 5:55A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 28, 1948, to Mar. 1, 1948, and that I last saw him alive on Mar. 1, 1948.

Immediate cause of death	Duration
Respiratory Failure	
Due to Intracranial Hemmorrhage	
Due to	
Other Conditions Multiple Contusions. (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Anthony F. DiPaula M.D.

Address St. Joseph's Hosp. Date signed 3/1/48

VS 150

G60747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G60748

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Mos. Sick
(e) Length of stay in Baltimore (yrs., mos., or days) 74 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto - 12 (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 Regester Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William O'Neill (WILLIAM WIRT O'NEILL)

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-12-1879

8. AGE: Years 68 | Months 3 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace Balto - Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business Store Manager- retired

FATHER
12. Name Peter O'Neill
13. Birthplace Md

MOTHER
14. Maiden Name Emmaline Taft
15. Birthplace Va

16 (a) Informant Elmer O'Neill
(b) Address 711 Regesta

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) 3/1/48 (Date rec'd by registrar) Evelyn Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 29 1948, at 8:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-24 1948 to 2-29 1948 and that I last saw h, alive on 2-29 1948

Immediate cause of death: Carcinoma of Colon
Due to: Carcinoma
Due to: Ca of Lung, Bone

Duration

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Ca of Lung, Bone

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William R Coat M. D.
Address Mercy Date signed 2-29-48

G60748

AB-117654

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 117B

G60748 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave. 6-1

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2808 Pulaski Highway (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laura Treder

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Married

6 (b) Name of husband or wife John William

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) July 6- 1884

8. AGE: Years	Months	Days	If less than one day
63	7	22	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name John Walper-D

13. Birthplace Germany

MOTHER

14. Maiden Name Elizabeth Krause -D

15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/48 (month) (day) (year)

(c) Cemetery or crematory Mount Carmel Cemetery Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.

(b) Address NORTH AVE. & BROADWAY

19 (a) 3/1/48 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28- 1948, at 4.40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-21- 1948, to 2-28- 1948, and that I last saw her alive on 2-28- 1948.

Immediate cause of death Tachycardia due to peritonitis, local

Due to Perforated duodenal ulcer

Due to Congestive Heart Failure Terminal Arteriosclerosis

Other Conditions Syphilis; Ventral Hernia; Bronchopneumonia

(Including pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No abnormal

Duration
?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. S. Parrott M. D.

Address Baltimore City Hosp Date signed 3/2/48

VS 150

660749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660749

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Le 9-9
(c) Hospital or institution: Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. [redacted] # I400 N. Caroline Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Rigley (William Joseph Rigley)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. N

4. Sex: M.

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Clara Mullen

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) About 1871

8. AGE: Years: About 76 77 | Months | Days | If less than one day: hr. min.

9. Birthplace Baltimore County
(Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name James Rigley
13. Birthplace Ireland

MOTHER
14. Maiden Name Susan O'Neil
15. Birthplace Ireland

16 (a) Informant Lillie Lida Fe Poe
(b) Address 1201 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/2/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) [illegible] (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1948, at 9:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1- 1948, to Feb 28 1948. and that I last saw him alive on Feb 28 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to	
Arteria Sclerosis	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Gill Hall M. D.
Address 1631 E Northern Date signed 3/1/48

VS 150

660750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 660750

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1810 N Fulton Ave
(c) Hospital or institution: 15-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 N Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederick L Ruff

3 (b) If veteran, name war: N

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Daisy A

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23 1879

8. AGE: Years 68 | Months 8 | Days 6 5 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Cooks Mother Colored

11. Industry or business Home Art.

FATHER
12. Name William Ruff
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary A Myers
15. Birthplace Baltimore Md

16 (a) Informant Charlotte L Ruff
(b) Address 1810 N Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 2 1948 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Wilhelm Cook Co
(b) Address 1217 E Cont St

19 (a) MAR 1 - 1948 (b) Christopher Williams Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 1948, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1947 to Feb 28 1948 and that I last saw h-im alive on Feb 28 1948

Immediate cause of death: cardiac asthenia

Due to: cardiac dilatation
cardiac muscular degeneration

Due to: Ch Bronchitis

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. E W Koons.
Address 1202 St Paul St Date signed 3/1/48 M. D.

G60751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G60751

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 15-17
(b) Street address
(c) Hospital or institution: Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Md~~ (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2803 Ulman Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose Klein

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife Morris Klein
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
51			hr. min.

9. Birthplace Rumania (Town, county, and state)
10. Usual Occupation house wife
11. Industry or business

FATHER
12. Name Isidore Isachrice
13. Birthplace Rumania.

MOTHER
14. Maiden Name Mary Moskowitz
15. Birthplace Rumania

16 (a) Informant Morris Klein
(b) Address 2803 Ulman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 2, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave Rosedale

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W. North Ave
Furniture from Williamsville, Mo.

MAR 1 1948 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/1/1948, at 2:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 26 Feb 1948, to 1 Mar. 1948, and that I last saw her alive on 1 Mar 1948.

Immediate cause of death	Duration
Metastatic carcinoma of right lung	4 yrs.
Due to Metastatic carcinoma of spine (thoracic)	5 yrs
Due to Carcinoma of breast	8 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold A. Weinberg M.D.
Address Doctors Hospital Date signed 3/1/48

VS 150

Harold A. Weinberg X

660752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

660752 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 16-5
(b) Street address
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2348 Mosher St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Irene Ida Asendorf

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 214-01-6912

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/7/1878

8. AGE: Years 69 | Months 10 | Days 27 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation L. Grief & Brothers

11. Industry or business

FATHER
12. Name John Asendorf
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Lerch
15. Birthplace Balto. Md.

16 (a) Informant Mr. Oscar Asendorf
(b) Address 1921 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) MAR 1 - 1948 (Date rec'd by registrar) (b) Lantzinger Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 29 1948 at 3:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 24 1948 to Feb. 29 1948 and that I last saw her alive on Feb. 29 1948.

	Duration
Immediate cause of death: Cerebral vascular accident	
Due to: Hypertensive C. V. D.	
Due to	
Other Conditions: Chronic nephritis, sclerosis, Uremia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Acute glomerular nephritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul D. Maumus M. D.
Address Bon Secours Hosp. Date signed 3/29/48

VS 180

Maumus 937

C60753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 60753

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 28-2

(a) Baltimore City, Maryland

(b) Street address Rayner Ave & Rutland St

(c) Hospital or institution: West Baltimore Gen'l Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3018 Fendall Road (If rural give location)

(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH MEIER

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NO

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary Meier

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1862

8. AGE: Years 86 | Months 7 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER

12. Name Frank Meier

13. Birthplace Austria

MOTHER

14. Maiden Name Elizabeth ?

15. Birthplace Austria

16 (a) Informant Mrs. Julia Hofmann

(b) Address 3018 Fendall Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/2/48 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Woodlawn Md.

18 (a) Funeral director George W. Little

(b) Address 2700 Edmondson Ave.

19 MAR 1 1948 (Date rec'd by Registrar) Washington Hollow Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 1948, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/26 1948 to 2/28 1948, and that I last saw him alive on 2/28 1948.

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Arteriosclerotic Heart Disease	
Nephrosclerosis & Uremia	
Other Conditions Laceration of neck 3" Burn left forearm	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: —

of autopsy: none

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide accident

(b) Date of occurrence 2/26/48 at 4 PM

(c) Where did injury occur? City (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? —

(e) Means of injury Slipped & Fell to cellar floor

23. Signature E. Robert Hardy

Address West Balt. Gen'l Hosp. M.D. Date signed 2/28/48

VS 150

Earl L. Royer M.D.

G60754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54 B

Registered No. G60754

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5606 Merville Avenue
(c) Hospital or institution: 27-19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 5606 Merville Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Daisy Litsinger Blakeney

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Charles L. Blakeney
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 17-1884
8. AGE: Years 63 | Months 6 | Days 12 | If less than one day: hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Harry T. Litsinger
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah E. Gillingham
15. Birthplace Maryland

16 (a) Informant Charles L. Blakeney
(b) Address 5606 Merville Avenue
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 2-1948 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Maryland
18 (a) Funeral director Durgee Funeral Home
(b) Address 3631 Falls Road
19 (a) MAR 1 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 29-1948, at 1 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1937 to Feb 29 1948 and that I last saw her alive on Feb 29 1948.

Immediate cause of death: Tumor of the brain, right side — Duration 11 yrs.
Due to Encephalitis — per
Due to Paralysis L. side of body — 2 yrs
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herman A. Mantz
Address 2601 Mankato Ave. Date signed 4/1/48

VS 159

660755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 660755

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1117 E. Monument St
(c) Hospital or institution: 5-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 E. Monument St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Hattie James Kennedy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife William H. Kennedy

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Jan. 25th 1895

8. AGE: Years 53 Months 1 Days 2 If less than one day hrs. min.

9. Birthplace Florence S. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jackson Gray
13. Birthplace S. C.

MOTHER
14. Maiden Name Laney Williams
15. Birthplace S. C.

16 (a) Informant William H. Kennedy
(b) Address 1117 E. Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-2-1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md.

18 (a) Funeral director Belson & Marnie H. Wright
(b) Address 721 Gilmor St

19 (a) MAR 1 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27th 1948 at 12:38 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/28 1947 to 2/27 1948, and that I last saw her alive on 2/27 1948

Immediate cause of death Cerebral Anaemia — Duration 1 week

Due to Myocarditis

Due to Hypertension

Other Conditions Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lloyd A. Lafond M. D.
Address 622 W. Biddle St Date signed 3/1/48

VS 153

937

G60756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. G60756

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution: St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Glen Burnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. Georgia Ave. & Maple Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beck, Adam Michael

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-0896

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	daughter

6 (b) Name of husband or wife Mrs. Eliz. Bauer
2026 E. Lanvale St., Balto. If dead, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1885

8. AGE: Years	Months	Days	If less than one day
62	7	12	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Ernest M. Beck
13. Birthplace Md

MOTHER
14. Maiden Name Mary A. Read
15. Birthplace Md

16 (a) Informant taken from chart Elizabeth
(b) Address 2024 E Lanvale Bauer

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 2 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo G. Crook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) MAR 1 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27, 1948, at 5:15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 22, 1948 to Feb. 27, 1948, and that I last saw him alive on Feb. 27, 1948

Immediate cause of death CARDIO-RESPIRATORY FAILURE — Duration

Due to CHRONIC LEUKEMIA (LYMPHOCYTIC)

Due to

Other Conditions ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry J. Houska, M.D.
Address St. Jos. Hosp. Date signed 2/27/48

VS 150

G60757

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 49a

Registered No. G60757

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2239 E. North Ave
(c) Hospital or institution: 8-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2239 E. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Ure Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Giles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 19th 1876

8. AGE: Years	Months	Days	If less than one day
71	4	5	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Samuel T. Crawley
13. Birthplace Md

MOTHER
14. Maiden Name Eliza J. McClelland
15. Birthplace Md

16 (a) Informant Giles E. Lewis
(b) Address 2239 E. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 2 48 (month) (day) (year)
(c) Cemetery or crematory Balto Mem.
Location North ave
18 (a) Funeral director Geo J Cook
(b) Address 1706 Patterson Park Ave

19 (a) MAR 1 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1948 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 25 1948 to Feb 27 48
and that I last saw her alive on Feb 26 1948

Immediate cause of death	Duration
Carcinomatosis	6 mo.
Due to Carcinoma of ovary	6 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Dec. 8, 1947
Major findings of operation: Carcinomatosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irvin Sauber M. D.
Address 3003 Jamison Blvd Date signed Feb 27, 48

VS 150

Irvin Sauber X

660758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 660758

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2074 Druid Park Drive
(c) Hospital or institution: 13-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2074 Druid Park Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Bosley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Jefferson D.

6 (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.) Sept 12 - 1866

8. AGE: Years	Months	Days	If less than one day
81	5	15	hr. min.

9. Birthplace Balto Co Md (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name Joshua Gill

13. Birthplace Unknown

MOTHER 14. Maiden Name Sarah Tracey

15. Birthplace unknown

16 (a) Informant Edna Wilson

(b) Address 1426 N 37th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 2-1948 (month) (day) (year)

(c) Cemetery or crematory St Mary's (Hampden)

Location Baltimore Md

18 (a) Funeral director Frank H Seitz

(b) Address 814 N 36th St

19 (a) MAR 1 - 1948 (Date rec'd by registrar) (b) [illegible] Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1948 at 10⁰⁰ M

21. I certify that I took charge of the remains described above, held an Aug & Insp thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature William S Selfridge M.D. Medical Examiner

Date signed Feb 28, 1948

VS 151

660759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. 660759

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1114 W 36th St.
(c) Hospital or institution: 13-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 W 36th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen M. Robson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Franklin T. Robson

6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) June 15 (1917) 1910

8. AGE: Years	Months	Days	If less than one day
37	8	16	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Seller.
13. Birthplace Virginia

MOTHER
14. Maiden Name Violetta Arrington
15. Birthplace Virginia

16 (a) Informant Franklin T. Robson.
(b) Address 1114 W 36th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 3/48 (month) (day) (year)
(c) Cemetery or crematory London Park.
Location Frederick Road.

18 (a). Funeral director Einstein E. Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) MAR 1 - 1948 (Date rec'd by registrar) (b) Thurston for Nathaniel, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 March 1948, at 12 M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of cervix uteri with Pelvic Metastasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D. Medical Examiner.
Date signed 1 March 1948

VS 181

660760

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1104a

Registered No. 660760

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Mary-Neck Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Douglas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
	6		hr. min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Clarence Douglas
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School FEB 24 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAR 2 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1948, at 3:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Upper Respiratory Infection

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 2-25-48

G60761

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. G60761

BC-48-00153 CERTIFICATE OF DEATH 106a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 21-1
(b) Street address
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1110 Warner Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Ann STREAB (STREAT)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months: 1 | Days | If less than one day: hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Mrs. Dorothy ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant ?
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School FEB 26 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAR 1 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17 1948 at 1 50 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute tracheo bronchitis
Status thymico lymphaticus

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George B. Merrill M.D.
Medical Examiner.
Date signed 2/17/48

VS 191

G60762

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 108

G60762
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 18-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 S. Carrollton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD WOOD.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years 40 ? | Months | Days | If less than one day hr. min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Chief Inspector's Office
(b) Address Police Department

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School FEB 26 1948

18 (a) Funeral director Commissioner of Health
(b) Address

MAR 1 - 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14, 1948, at 12 p.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Lobar pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 2-16-48

VS 151

X

660763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 660763

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 7-4
(b) Street address
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1806 E. Eager St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation ?

11. Industry or business ?

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School FEB 26 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (Date rec'd by registrar MAR 1 - 1948) Penelope Hillis M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12 1948, at 8 25 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary arteriosclerosis
Coronary thrombosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Mirell M.D.
Medical Examiner.

Date signed 2/12/48

VS 151

G60764

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G60764 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 231 N. Pearl St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Bagley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation "

11. Industry or business "

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 25 1948

18 (a) Funeral director Commissioner of Health
(b) Address Huntington Williams, M.D.

19 (a) MAR 1 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18 1948, at 4:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspecting thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl V. Reyn M.D. (Medical Examiner)
Date signed 2-19-48

VS 151

G60765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 1643

G60765 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3-1
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 E. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME RALPH RAINWATER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years	Months	Days	If less than one day
42			hr. min.

9. Birthplace Unknown (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 25 1948

18 (a) Funeral director Commissioner of Health
(b) Address Huntington Millname, M.D.

19 MAR 1948 (Date rec'd by Registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1, 1948, at 8.10 p. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-1-48 at 8.45 p. M.
(b) Where did injury occur? Pier #6-Pratt St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Jumped in harbor

23. Signature George L. Magill M.D. Medical Examiner.
Date signed 2/2/48

X

660766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC = 48-03258 159

Registered No. 660766

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Ave 26-4
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 368 Roberts Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Walters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/13/48

8. AGE: Years	Months	Days	If less than one day
			11 hr. 43 min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Otto C Walters
13. Birthplace

MOTHER
14. Maiden Name Juanita Sprinkle
15. Birthplace Md

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location Johns Hopkins Medical School FEB 18 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 1 - 1948 (Date rec'd by registrar) Harrington-Williams U.P.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13/48 19 at 5:35A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/13 1948 to 2/13 1948 and that I last saw him alive on 2/13 1948

Immediate cause of death Respiratory failure

Due to Prematurity (28wks)

Due to pregnancy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. E. Sanger M. D.
Address St. Agnes Hosp. Date signed 2/14/48

VS 190

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G60767

BS 48 01158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160c

Registered No. G60767

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St.
(c) Hospital or institution: Sinai Hospital 15-13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 11 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3524 Virginia Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Josephson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: wht.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1948

8. AGE: Years NB | Months | Days | If less than one day 6 hrs min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Samuel Josephson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Hannah Meyers
15. Birthplace Baltimore, Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 27, 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20, 1948, at 5:45 AM

22. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19, 1948, to Jan. 20, 1948. and that I last saw h[illegible] alive on Jan. 20, 1948.

Immediate Cause (a) Atelectasis

Due to Prematurity

Due to Premature Rupture of Membranes

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Rud M. D.

Address Date signed

X

60768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1577

60768 ✓ Registered No.

SC-48-03963

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette Sts
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (~~yrs. mos. or~~ days) 27
(e) Length of stay in Baltimore (~~yrs. mos. or~~ days) /

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2817 Woodland ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Coates

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-20-48

8. AGE: Years | Months | Days | If less than one day — hr. 40 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name A. Raymond Coates Jr
13. Birthplace

MOTHER
14. Maiden Name Mary Reynolds
15. Birthplace Maryland

16 (a) Informant A Raymond Coates Jr
(b) Address 2817 Woodland ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School FEB 26 1948
Loc.

18 (a) Funeral director Commissioner of Health
(b) Address

MAR 1 - 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 1948 at 11:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-20-1948 to 2-20-1948 and that I last saw h[illegible] alive on 2-20 1948

Immediate cause of death Prematurity

Due to mal development

Due to

Other Conditions meningo-encephalocele

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Raymond Coates Jr M. D.
Address Franklin Square Hosp Date signed 2/20/48

159

C60769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC-4P-04016 159

Registered No. C60769

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 Argyle Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Harris #2 Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/3/48

8. AGE: Years | Months | Days | If less than one day: 20 hr. 1 min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Claiborne Harris
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Bernice Contrumme
15. Birthplace Balto., Md.

16 (a) Informant Bernice Harris
(b) Address 1105 Argyle Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location Johns Hopkins Medical School FEB 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 1 - 1948 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3 1948 at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2 1948 to Feb. 3 1948, and that I last saw her alive on Feb. 3 1948.

Immediate cause of death: Asphyxia (Birth)
Due to: Atelectasis
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 54 Walker Date signed 2-5-48

VS 150

G60770 G60770

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home + Hosp Ltd 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 928 N Bentalou Ln
(If rural give location)
(e) Citizen of foreign country? Md (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Bertha a Shipperling

3 (b) If veteran, name war NO

3 (c) Social Security Account No. 705-03-7552

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Geo. P. — (dead)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 1, 1886

8. AGE: Years 61 Months 6 Days 29 If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Retired B+O RR.

FATHER 12. Name Charles Rutter

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden Name Sophia Wyatt

MOTHER 15. Birthplace Maryland

16 (a) Informant (Mrs) Betty E Shipperling

(b) Address Upperco Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/48 (month) (day) (year)

(c) Cemetery or crematory. Balto. Cem.

Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner + Sons

(b) Address Baltimore, Md.

19 (a) 1948 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 19 48 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/27/ 19 48 to 2/28/ 19 48 and that I last saw h alive on 2/28 19 48.

Immediate cause of death Cardiac insufficiency — Duration 6 mo.

Due to Arteriosclerotic heart disease — 10 yrs

Due to Arteriosclerotic general — 10 yrs

Other Conditions Edema, pulmonary — 1 day.
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stanley Backanich M. D.
Address Church Home + Hosp Date signed 2/28/48

G60771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 162 B

G60771 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6017 York Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-12
(e) Length of stay in Baltimore (yrs., mos., or days) 93-11-29

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6017 York Road (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Sarah Josephine Bradley
3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife deceased J. Louis Bradley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-18-1854

8. AGE: Years	Months	Days	If less than one day
93	11	11	17 hr. 30 min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Cipriano Fernandin
13. Birthplace Corsica

MOTHER
14. Maiden Name Not known to deceased
15. Birthplace daughter

16 (a) Informant Mrs. Michael V. Conte
(b) Address 6017 York Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 2-48 (month, day, year)
(c) Cemetery or Crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Wm McElfish Sons
(b) Address North & Pa Aves

19 (a) (Date rec'd by registrar) (b) Washington Hollow Baltimore Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 29 1948, at 3.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1948 to Feb. 29 1948, and that I last saw him alive on 2-29 1948.

	Duration
Immediate cause of death Cardiac Failure	24 hrs
Due to Old General Debility	4 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M E Cole M. D.
Address 6014 York Road Date signed 2-29-48

G60772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G60772
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3300 W Calvert
(c) Hospital or institution: Union Memorial Hosp. 27-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mo 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4415 Greenway (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME MARY SELINA GRIFFIN

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 28, 1882.

8. AGE: Years	Months	Days	If less than one day
65	9	1	hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation Real Estate
11. Industry or business SELF.

FATHER
12. Name Edwin A. Griffin
13. Birthplace Md.

MOTHER
14. Maiden Name Alice Rinehise
15. Birthplace MD.

16 (a) Informant MRS Roy E. Hobgats
(b) Address 4415 Greenway

17 (a) (Burial, cremation, or removal) (b) Date thereof 3/3/48 (month) (day) (year)
(c) Cemetery or crematory GREENMOUNT
Location BALTIMORE, MD.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Baltimore, MD.
Washington National, Md.

19 (a) 1-1948 (Date rec'd by registrar) (b) D Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 29 1948, at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1947 to Feb 29 1948, and that I last saw h.e.s. alive on Feb 29 1948

Immediate cause of death	Duration
Papillary Adenocarcinoma of Ovary, Right	
Due to Terminal Cachexia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 4/23/47 Papillary
Major findings of operations Cystadenocarcinoma Right Ovary
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Smith, Jr. M. D.
Address Union Memorial Hospital Balto. 18, Md. Date signed 3/2/48

VS 150

G60773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 13 a

G60773 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6000 BELLONA AVE

(c) Hospital or institution: EDGEWOOD NURSING HOME

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 5002 CATAWBA RD. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SOPHIA K. BURMAN

3 (b) If veteran, name war No | 3 (c) Social Security Account No. No

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife HENRY E. BURMAN 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG 12, 1859

8. AGE: Years 88 | Months 6 | Days 16 | If less than one day hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business —

FATHER 12. Name HENRY AMRHEIN

13. Birthplace GERMANY

MOTHER 14. Maiden Name UNKNOWN

15. Birthplace GERMANY

16 (a) Informant MR. R. W. BURMAN - SON

(b) Address LARCHMONT, N.Y.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/3/48 (month) (day) (year)

(c) Cemetery or crematory LOUDON PK.

Location BALTIMORE, MD

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address BALTIMORE, MD.

MAR 1 - 1948 Burial Permit Williams, Mgr.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/28/48, 19—, 9.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1947 to Dec 28 1948 and that I last saw h[illegible] alive on Dec 28 1948

Immediate cause of death: Chronic Myocarditis mdy — Duration

Due to —

Due to —

Other conditions Arteriosclerosis mdy & Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury —

23. Signature [signature]

Address 117 W. 25th St. Date signed 2.29.48

93D

G60774

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G60774
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3142 BAKER ST.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3142 BAKER ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country —

3 (a) FULL NAME: AUGUST WILLIAM DESOR. JR.

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No.: No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife: MARY NOWLIN DESOR
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): AUG 28, (1888)

8. AGE: Years	Months	Days	If less than one day
60 (59)	6	3	hr. min.

9. Birthplace: BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation: GROCERY - (RETIRED)
11. Industry or business

FATHER
12. Name: AUGUST W. DESOR SR.
13. Birthplace: GERMANY

MOTHER
14. Maiden Name: ANNA STEINDACK
15. Birthplace: BALTO., MD.

16 (a) Informant: MRS. MARGARET WENER (DAUGHTER)
(b) Address: 3142 BAKER ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/4/48 (month) (day) (year)
(c) Cemetery or crematory: LOUDON PK.
Location: BALTIMORE, MD.

18 (a) Funeral director: WM. F. TICKNER & SONS
(b) Address: BALTIMORE, MD.

19 (a) — 1948 (Date rec'd by registrar) (b) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/1, 1948, at 5:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to 3/1, 1948 and that I last saw h[illegible] alive on 2/29, 1948

Immediate cause of death: Arteriosclerotic Cardio-Vascular Disease — Duration: 2 years

Due to:

Due to:

Other Conditions: Coronary Thrombosis — 36 hours

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: A. A. Sussman M.D.
Address 1109 N. Calvert St Date signed 3/1/48

VS 150

660775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 660775

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 rd Calvert St.
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Queen Anne
(c) City or town Church Hill
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie B. Rochester

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	single

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 5, 1883

8. AGE: Years	Months	Days	If less than one day
64	2	27	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John McCleary Rochester
13. Birthplace Maryland

MOTHER
14. Maiden Name Ellen M Sadler
15. Birthplace Maryland

16 (a) Informant Hospital
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-4-48 (month) (day) (year)
(c) Cemetery or crematory Church Hill
Location Church Hill Md

18 (a) Funeral director Belfon & Lane
(b) Address Church Hill Md

MAR 2 - 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-1 1948 at 6:12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 25 1948 to Mar 1 1948 and that I last saw h[illegible] alive on 3-1 1948

Immediate cause of death	Duration
Ruptured left ventricle	1 minute
Due to Myocardial infarction (acute)	1 wk
Due to	
Other Conditions Hydrothorax	5 days

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations

of autopsy Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. A. Gregory, Jr. M. D.
Address Union Memorial Hosp Date signed 3-1-48

VS 150 - ...

G60776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V55E

Registered No. G60776

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 27-18
(b) Street address
(c) Hospital ~~or institution~~: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4969 Edgemere Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John H. Brough

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Margaret E. Brough
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 20th 1870

8. AGE: Years	Months	Days	If less than one day
77	8	11	hr. min.

9. Birthplace Penna (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Parisienne Dyeing Co

FATHER
12. Name Unknown Brough
13. Birthplace "

MOTHER
14. Maiden Name Alice Shue
15. Birthplace Md.

16 (a) Informant Margaret E. Brough
(b) Address 4969 Edgemere Ave

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 3/3/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 MAR 2 - 1948 [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/1 1948 at 12 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/29 1947 to 3/1 1948 and that I last saw h[illegible] alive on 2/25 1948.

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other Conditions Lymphosarcoma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bronchopneumonia - lymphosarcoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 3/1 M. P. 48

VS 150

107

G60777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G60777

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days): 1 wk.

2. USUAL RESIDENCE OF DECEASED:
(a) State: NY (b) County:
(c) City or town: Long Island (If outside city or town limits, write RURAL and give town)
(d) Street No.: Belmont Rd. North Babylon (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Lee Alexander

3 (b) If veteran, name war:

3 (c) Social Security Account No.: 088-16-8131

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Mable Hill Alexander
6 (c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): June 1, 1896

8. AGE: Years	Months	Days	If less than one day
51	9	0	hr. min.

9. Birthplace: Chicago, Ills. (Town, county, and state)
10. Usual Occupation: Chief Engineer
11. Industry or business: Seafarer

FATHER
12. Name: Jesse Alexander
13. Birthplace: Mo.

MOTHER
14. Maiden Name: Katherine Leigh
15. Birthplace: Ill.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof: 3/2/48 (month) (day) (year)
(c) Cemetery or crematory: Evergreen
Location: Brooklyn N.Y.

18 (a) Funeral director: William Cook Co
(b) Address: 1217 E Fort Ave

19 MAR 2- 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1 1948, at 7:40A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 1 1948 to Mar. 1 1948, and that I last saw him alive on Mar. 1 1948.

Immediate cause of death	Duration
Arteriosclerosis, Coronary artery & heart;	
with Occlusion and Myocardial infarction	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Frank B. Sulle M.D. M. D.
Address: U.S. Marine Hospital Date signed: 3-4-48
Balto, Md

VS 150

G60778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. G60778

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 819 N. Eaton St
(c) Hospital or institution: 11-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 819 N. Eaton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida E Hurley

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Kirby Hurley
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 5 1877

8. AGE: Years 70 | Months 10 | Days 23 | If less than one day: hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: Wilson Smallwood
13. Birthplace: Baltimore Md

MOTHER
14. Maiden name: Margaret Seymour
15. Birthplace: Baltimore Md

16 (a) Informant: Mary E Quick
(b) Address: 1014 N Calvert St

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof: 2/5/48 (month) (day) (year)
(c) Cemetery or crematory: Mt Olivet
Location: Baltimore Md

18 (a) Funeral director: Wilson Conroe
(b) Address: 1219 E Fort Ave

(Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 193

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 28 1948, at 7:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 26 1948 to 2/28 1948, and that I last saw h alive on 19

Duration
Immediate cause of death: (a) Cerebral Hemorrhage — 2 dy
Due to:
Due to:
Other Conditions: High Blood Pressure

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: H. C. Hearne M. D.
Address: 790 Harlem Ave Date signed: 3/1/48

G60779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G60779

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 109 E. CROSS ST
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 109 E. CROSS ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME NATHAN E. WATSON

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife MABEL (GRANGER)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 19, 1885

8. AGE: Years	Months	Days	If less than one day
62	7	9	hr. min.

9. Birthplace PRINCE GEORGE CO. (Town, county, and state)
10. Usual Occupation CARPENTER
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace "

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace "

16 (a) Informant MR. WILLIAM H. WHITE
(b) Address 924 W. PRATT ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3 2 48 (month) (day) (year)
(c) Cemetery or crematory GLEN HAVEN
Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F. DENNY, INC
(b) Address 715 LIGHT ST.

MAR 2 1948 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/28 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1948, to 2/27 1948, and that I last saw h[illegible] alive on 2/27 1948

Immediate cause of death	Duration
Hypostatic pneumonia	7
Due to Bronchopneumonia	
Due to Neoplasm of Stomach	
Due to —	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. Greenberg M. D.
Address 107 E. Wash St Date signed 2/28/48

X

G60780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

Registered No. G60780

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3-1
(c) Hospital or institution: Balto. city Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 E. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Raymond Dean

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Richard Dean

13. Birthplace Md

MOTHER 14. Maiden Name Sarah Harris

15. Birthplace Md

16 (a) Informant Goldie Deans

(b) Address Cambridge Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 4/48 (month) (day) (year)

(c) Cemetery or crematory Cemetery

Location Pioneers Road Fork

18 (a) Funeral director Lewis H Bayne

(b) Address Cambridge Md

19 (a) MAR 2, 1948 (Date rec'd by Registrar) (b) Huntington W Jones M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1948 at 9:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Ruptured aneurysm of thoracic aorta with

Due to: cardiac tamponade

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Emmett Boyer M.D. Medical Examiner.

Date signed 3-1-48

VS 151 17 .614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 60781

60781

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1244 James St
(c) Hospital or institution: 21-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1244 James St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laura V. Gardner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Harry K.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27, 1884

8. AGE: Years 63 | Months 5 | Days 1 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation —
11. Industry or business

FATHER 12. Name William McCormick
FATHER 13. Birthplace Maryland
MOTHER 14. Maiden Name Sarah Ellen Packard
MOTHER 15. Birthplace Maryland

16 (a) Informant Mr. Harry K Gardner
(b) Address 1244 James St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-2-48 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location 2330 Frederick St.

18 (a) Funeral director Harry A Waltke
(b) Address 1601 Edmondson Ave

MAR 2 - 1948 (Date rec'd by registrar) (b) Washington for Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 1948 at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from DEC 1937 to 28 FEB 1948 and that I last saw h[illegible] alive on 28 FEB 1948

Immediate cause of death Rheumatic Heart Disease | Duration 10 YR

Due to Rheumatic Fever

Due to

Other Conditions Chronic Hypertension Arthritis OTR

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: No

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward T. Nolan M.D.
Address 682 Washington Blvd Date signed 1 Mar 48

Baltimore 30 Md.

VS 150

660782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

Registered No. 660782

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507 S. COLLINS AVE
(c) Hospital or institution: 20-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 507 S COLLINS AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: EDWARD W. LINTHICUM

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-01-4959

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOW

6 (b) Name of ~~husband~~ or wife Lot. ELIZABETH (KRAUSS)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 15, 1863

8. AGE: Years	Months	Days	If less than one day
85	1	14	hr. min.

9. Birthplace ANNAPOLIS MD
(Town, county, and state)
10. Usual Occupation WATCHMAN
11. Industry or business WICKENS DAIRY

FATHER
12. Name JAMES LINTHICUM
13. Birthplace MD

MOTHER
14. Maiden Name —
15. Birthplace MD

16 (a) Informant MRS ELIZABETH SMITH
(b) Address 507 S COLLINS AVE

17 (a) BURIAL (b) Date thereof MARCH 3 '48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory BALTIMORE
Location E. NORTH AVE

18 (a) Funeral director Harry A. Wilson
(b) Address 401 Edmondson Ave.

19 (a) MAR 2 1948 (b) Hunting for Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 29 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 18 Feb 1948 to 29 Feb 1948 and that I last saw him alive on 29 Feb 1948

Immediate cause of death: Pulmonary Edema
Broncho Pneumonia
Due to Rheumatic CV Disease
Hypertensive CV Disease
Due to Arteriosclerosis

Other Conditions Bronchiectasis
Senility
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration
35 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H H Bayless M. D.
Address 600 Wilkens Ave Date signed 1 Mar 48

VS 180 . . .

G60783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1316

Registered No. G60783

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address or
(c) Hospital or institution: 229- Beale Court. 6-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) Country
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 229- Beale Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Evans Sr.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M. | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18 1901

8. AGE: Years 46 47 | Months 11 | Days 8 | If less than one day hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Evans Sr.
13. Birthplace N. C.

MOTHER
14. Maiden Name Nancy ?
15. Birthplace N. C.

16 (a) Informant Mary Evans
(b) Address 1617 Pearl St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-4-48 (month) (day) (year)
(c) Cemetery or crematory Location Mt. Calvary

18 (a) Funeral director A. Haldeman & Lloyd Field
(b) Address 1617 Pearl St.

MAR 2 - 1948 (Date rec'd by registrar) (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-26-1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-24 1948 to 2-26 1948 and that I last saw him alive on 2-26 1948

Immediate cause of death Pulmonary tuberculosis — Duration 4 months
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. B. Watts M. D.
Address 515 Washington Date signed 3-1-48

X

G60784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Registered No. G60784

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1801 Baker St
(c) Hospital or institution: 15-

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1801 Baker St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Silverstein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation shoe maker
11. Industry or business

FATHER
12. Name Aaron
13. Birthplace Poland

MOTHER
14. Maiden Name Fagin
15. Birthplace Poland

16 (a) Informant Rose Silverstein
(b) Address 1801 Baker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-2-48 (month) (day) (year)
(c) Cemetery or crematory Levy Herzog Nebraska
Location Levy Herzog Nebraska

18 (a) Funeral director Jack Rewbo Inc
(b) Address 2100 Eutaw Place

19 MAR 2 1948 (Date rec'd by Registrar) (By) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-2- 1948 at 12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 29 1947 to March 2 1948
and that I last saw him alive on March 2 1948

Immediate cause of death	Duration
Bordine failure	7 Days
Due to Chronic Myocarditis	2 yrs
Due to Ch Nephritis	"
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M.J. Bayless
Address 3040 Eutaw Date signed 3/2-48

VS 150

G60785 1 Copy

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 61

G60785 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1430 John St.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1430 John St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) no
If yes, name country

3 (a) FULL NAME Edwin Anderson Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary T. Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 8, 1878

8. AGE: Years 69 | Months 2 | Days 6 | If less than one day hr. 24 min.

9. Birthplace: Virginia 1864-1945 (Town, county, and state)

10. Usual Occupation C. P. A.

11. Industry or business

FATHER
12. Name Carter Nelson Williams
13. Birthplace Va.

MOTHER
14. Maiden Name Rosa B. Haskins
15. Birthplace Va.

16 (a) Informant Robert L. McDowell
(b) Address 1208 Bolton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave., Baltimore, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 MAR 2 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

Vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1, 1948, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to Mar 1 1948.
and that I last saw h alive on Jan 31 1948.

Immediate cause of death	Duration
Coronary Thrombosis	Sudden
Due to Arteriosclerosis	Gradual
Due to Myocarditis	"
Due to Diabetes Mellitus	"
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. A. Reedy M. D.
Address 1403 Park ave Date signed 3-2-48

Howard J. Andersen, M.D.
Dr. Reedy

G60786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

✓ G60786 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3906 Canterbury Road
(c) Hospital or institution: none 12-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 60 years
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3906 Canterbury Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Edgar R. Zimmerman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Elizabeth Candy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27, 1876

8. AGE: Years 71 | Months 11 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Insurance broker

11. Industry or business

FATHER
12. Name Rev. George H. Zimmerman
13. Birthplace Charlestown, Md.

MOTHER
14. Maiden Name Henrietta Rowe
15. Birthplace Charles County, Md.

16 (a) Informant Mrs. Eleanor S. Keeney
(b) Address Montrose Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/48 (month) (day) (year)
(c) Cemetery Romney
Location Romney, W. Va.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

MAR 2 - 1948 (Date rec'd by registrar)

(b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1948, at 3:37A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/24 1946 to 3/1/ 1948 and that I last saw h im alive on 2/29 1948.

Immediate cause of death Careinoma of the prostate with metastases to the ribs, spine and pelvis — Duration: 3 to 4 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin B Jarrett M.D.

Address 11 E. Chase St. Date signed 3/1/48

VS 150

Dr. Jarrett X

G60787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G60787

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: 28-1
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 46 d
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto. Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 5346 Reisterstown Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Carolyn McClure

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex F | 5. Color or race Wh | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife O. Raymond McClure
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 1899

8. AGE: Years 48 | Months 4 | Days – | If less than one day ... hr. ... min.

9. Birthplace Long Island N.Y. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Julius Ferri
13. Birthplace Italy

MOTHER
14. Maiden Name Mary Jane Higgins
15. Birthplace N.Y.

16 (a) Informant O. Raymond McClure
(b) Address 5346 Reisterstown Road

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Mch 4 1948 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3501 Fredrick ave

18 (a) Funeral director John D. Mitchell Sons
(b) Address 1900 Eutaw Place
(c) Huntington Williams, M.D. Registrar

MAR 2 – 1948 (Date rec'd by registrar)

Vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1948 at 5 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14 1948 to Mar 1 1948, and that I last saw her alive on Feb 29 1948.

Immediate cause of death Generalized Cardio-vas cular Collapse

Due to Hypertensive cardio-vascular disease

Due to

Other Conditions Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Emergency
Address Univ. Hosp. Date signed 3-1-48 M. D.

C60788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. C60788

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1506 madison ave
(c) Hospital or institution: 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 madison ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie Jones

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife Daniel Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 27 1877

8. AGE: Years	Months	Days	If less than one day
71	—	—	hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Robert Burrell
13. Birthplace Va

MOTHER
14. Maiden Name Josephine Lockley
15. Birthplace Va

16 (a) Informant annie Willis
(b) Address 1506 Madison ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-2-48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Md

18 (a) Funeral director George G. Kelson
(b) Address 1303 Eutaw St

19 MAR 9 1948 (Date rec'd by Registrar) (b) [illegible] (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1948, at 10 3/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1948 to Feb 27 1948 and that I last saw h[illegible] alive on Feb 26 1948.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerosis (Chr)	
Due to Myocarditis (Chr)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. T. Howell M.D.
Address 1001 N. Carrollton Ave Date signed 3/4/48

VS 150

660789

AB-117698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH. 13 B

660789 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 North Bruce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Harley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Gloria
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2-1927

8. AGE: Years	Months	Days	If less than one day
20	8	26	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Oscar Harley
13. Birthplace N.C.

MOTHER
14. Maiden Name Essie Staley
15. Birthplace S.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-4-48 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Mt. Auburn

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna Ave

MAR 2 - 1948 (Date rec'd by registrar) (b) Huntington-Williams M.F. Registrar

MEDICAL CERTIFICATION

AM

20. DATE OF DEATH Feb. 28 1948, at 2.30M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-24 1948, to 2-28 1948, and that I last saw him alive on 2-28 1948.

Immediate cause of death Pulmonary Tuberculosis

Due to

Due to

Other Conditions Tuberculosis Empyema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. R. Hearn M. D.
Address Balto City Hosp Date signed 2-28-48

VS 150

G60790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No. G60790

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1616 Delano ct
(c) Hospital or institution: 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Delano ct
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Femal | 5. Color or race: Colored | 6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~: married

6 (b) Name of husband or wife: James allen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 54 | Months | Days | If less than one day hr. min.

9. Birthplace Balto. md
(Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant James allen
(b) Address 1616 Delano. ct

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-48 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Mt. Auburn

18 (a) Funeral director William a. Jackson
(b) Address 916 Penna. Ave

MAR 2 - 1948 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

VS 133

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1948 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 8 1948 to Feb 26 1948 and that I last saw h~~e~~ alive on Feb 2 1948

Immediate cause of death: Aortic Heart Disease — Duration: 9

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Wallace M. D.

Address 764 Hoadley Ave. Date signed 3-28-48

G60791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G60791

G60791

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 804 W. Lanvale st
(c) Hospital or institution: 17-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 56

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 804 W Lanvale st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Jerome Credith

3 (b) If veteran, name war: world War # 1
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Mabel W. Credith
6 (c) If married, give age years

7. Birth date of deceased (mo., day, yr.) (Sept) 9-1892

8. AGE: Years 55 (56) Months (5) Days (19) If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation unemployed Post Office
11. Industry or business

FATHER
12. Name John a. Credith
13. Birthplace Va

MOTHER
14. Maiden Name Quintina
15. Birthplace Va.

16 (a) Informant Mabel W. Credith
(b) Address 804 Lanvale st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-2-48 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Balto National

18 (a) Funeral director William a. Upcham
(b) Address 916 Penna Ave

MAR 2 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 1948, at 1a M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1c 1947 to 2-28 1948 and that I last saw h alive on Feb 28 1948

Immediate cause of death
Due to
Due to
Other Conditions Coron-Vascular-Heart disease
(Include pregnancy within 3 months of death)

Duration: 1 da; 7

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles T. Woodland M. D.
Address 14 Stafford Date signed 2-29-48

Charles T. Woodland 83a

G60792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G60792

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 5
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St
(c) Hospital or institution Good Samaritan Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1121 Comit st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bennie Meyers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Mal.	Colored	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years	Months	Days	If less than one day
84			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Brennan
(b) Address 314 Lafayette ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-3-48 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Mt. Auburn

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna ave

19 (a) MAR 2- 1948 Huntington Williams, M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1948, at 5-30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1948, to Feb 28 1948, and that I last saw h[illegible] alive on Feb 28 19

Immediate cause of death	Duration
Cardiac Failure	
Due to Generalized Arteriosclerosis	?
Due to Senility	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stella Tompreas M.D.
Address 1348 Block St. Date signed Feb 28

VS 150

Stella Tompreas X

G60793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 207

Registered No. G60793

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 Cox Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edmund F. Howard

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-2920

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Annabelle H. Howard

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1899

8. AGE: Years	Months	Days	If less than one day
49	1	24	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Crown Cork & Seal Co.

FATHER
12. Name Moses M. Howard
13. Birthplace Maryland

MOTHER
14. Maiden Name Laura Thomas
15. Birthplace Maryland

16 (a) Informant Annabelle H. Howard
(b) Address 1206 Cox Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 3 1948 (month) (day) (year)
(c) Cemetery or crematory Poplar
Location Balto Co.

18 (a) Funeral director Paul E. Lehnerwith Jr.
(b) Address 3615-17 Chestnut Ave.

MAR 2 - 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Feb 1948, at 11:10 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Emphysema
Edmund Howard
Due to Hypertension A.S.C.J. Prior

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D. Medical Examiner
Date signed 29 Feb 48

VS .191

G60794

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G60794

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 4-1
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. New Howard Hotel (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Benjamin Landauer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7 1860

8. AGE: Years	Months	Days	If less than one day
87	4	22	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James Landauer
13. Birthplace Germany

MOTHER
14. Maiden Name Sophie Meda
15. Birthplace Germany

16 (a) Informant Mrs. Wayne Jacobs
(b) Address 11 E. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/2/48 (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Sonnheim & Son
(b) Address 1702 Eutaw Place

19 MAR 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 29 1948 at 4 55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-26 1948 to 2-29 1948 and that I last saw him alive on 2-29 1948.

Immediate cause of death	Duration
Cardiac arrest	
Due to Arteriosclerotic C-V Disease	
Due to	
Other Conditions Bronchopneumonia, RLL	4 days
Generalized arteriosclerosis, sing, hernia + (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard S. Cohen M. D.
Address Sinai Hosp., Balto., Md. Date signed 2-29-48

VS 190

X

G60795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G60795

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PERSONS RESPONSIBLE FOR FINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2429 Fait Ave
(c) Hospital or institution: 1-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2429 Fait Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Frank A Januszeski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Anna Margaret (nee Hartka) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/18/1878

8. AGE: Years	Months	Days	If less than one day
69	2	10	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Anna M. Januszeski - wife
(b) Address 2429 Fait Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

MAR 2 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28, 1948, at 8 10 P M

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William F Helfrich M.D. (Medical Examiner)
Date signed 2/29/48

VS 181

G6D796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G6D796

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 948 Harlem Ave,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 948 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie E. Wilson,

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	married

6 (b) Name of husband or wife Robert T. Wilson,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 25, 1904

8. AGE: Years	Months	Days	If less than one day
43	2	3	hr. min.

9. Birthplace Danville, Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Watkins,
13. Birthplace Danville, Virginia

MOTHER
14. Maiden Name Delrice Walker,
15. Birthplace Danville, Virginia

16 (a) Informant Robert T. Wilson
(b) Address 948 Harlem Ave,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 2, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) MAR 2 - 1948 (Date rec'd by registrar) (b) Registrar Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/28 1948, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/24/48 to 2/28/48, and that I last saw h alive on 2/28/48

Immediate cause of death	Duration
Cerebral	2/24/48
Due to Hemorrhage	to 2/28/48
Due to	
Other Conditions Hypertensive	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. A. Wilcox M. D.
Address 1131 Harlem Ave Baltimore 3/2/48

VS 150

660797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

Registered No. 660797

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: 12-6

(a) Baltimore City, Maryland

(b) Street address 1708 Eutaw Pl.

(c) Hospital or institution: Elmhurst Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town 38 E. 27th St. (If outside city or town limits, write RURAL and give town)

(d) Street No. Baltimore (If rural give location)

(e) Citizen of foreign country? F (Yes or No)

If yes, name country

3 (a) FULL NAME William E. Carter

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: No

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Sophia M. Carter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1863

8. AGE: Years 84 Months 3 Days 22 If less than one day ____ hr. ____ min.

9. Birthplace Balto. MD. (Town, county, and state)

10. Usual Occupation Tailor - Retired

11. Industry or business —

FATHER 12. Name William Carter

13. Birthplace Ireland

MOTHER 14. Maiden Name Margaret Burmingham

15. Birthplace Ireland

16 (a) Informant Miss Helen V. Carter Daughter

(b) Address 38 E. 27th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tichner & Sons

(b) Address Baltimore 1, MD.

19 (a) Date received (Registrar) (b) Registered by (Registrar) Courtenay Williams MD

MAR 2 1948

VS 150

MEDICAL CERTIFICATION March 1-48

20. DATE OF DEATH March 1 19 48, at 12 noon M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1947 to Feb 29 1948 and that I last saw him alive on Feb. 29 1948.

Immediate cause of death: Cerebral Hemorrhage

Due to: adv. Atherosclerosis

Due to:

Other Conditions: Ca {Basal cell} none

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Louis L. Jacobs M. D.

Address 1700 Eutaw Pl. Date signed 3-1-48

Louis L. Jacobs 83a

G60798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G60798

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 16-7

(a) Baltimore City, Maryland

(b) Street address 2117 DENISON ST.

(c) Hospital or institution: CRAWFORD RETREAT

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 3320 POPLAR ST. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country —

3 (a) FULL NAME LAURA ADELE ROSS

3 (b) If veteran, name war No | 3 (c) Social Security Account No. No

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife GEO. W. ROSS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 3, 1869

8. AGE: Years 78 | Months 9 | Days 26 | If less than one day hr. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business —

FATHER 12. Name HENRY W. MOORE

13. Birthplace MARYLAND

MOTHER 14. Maiden Name UNKNOWN

15 Birthplace "

16 (a) Informant MR. EDWARD D. ROSS (SON)

(b) Address 3320 POPLAR ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/2/48 (month) (day) (year)

(c) Cemetery or ~~crematory~~ WESTERN

Location BALTIMORE, MD.

18 (a) Funeral director Wm. J. TICKNER & SONS

(b) Address BALTIMORE ~~Williamsport, Md.~~ (Cemetery or Crematory)

19 (a) MAR 2 1948 (b) (By ... (Year)) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/29/48 19—, at 12 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1938 19 to 2/29 1948, and that I last saw her alive on 2/28 1948.

Immediate cause of death	Duration
Cardio-vascular hypertensive disease	5 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Norman A. Todd

Address 2108 St Paul St Date signed 3/1/48 M. D.

VS 130

X

660799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 660799

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy 27-11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 months
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ------
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Loyola Charles St + Cold Spring Ln.
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Fath. Louis E. McKay S.J.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-19-1889

8. AGE: Years	Months	Days	If less than one day
58	11	11	..... hr. ..... min.

9. Birthplace Penn (Town, county, and state)

10. Usual Occupation Priest

11. Industry or business

FATHER
12. Name Alexander McKay
13. Birthplace Scotland

MOTHER
14. Maiden Name Elizabeth Murray
15. Birthplace Scotland

16 (a) Informant Same
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/48 (month) (day) (year)
(c) Cemetery or crematory Woodstock College
Location Woodstock, Md.

18 (a) Funeral director H. D. Means and Son
(b) Address 805 N. Calvert Street

19 (a) MAR 2 - 1948 (Date rec'd by registrar) (b) Huntington, Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-1 1948, at 6 05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-29 1947 to 3-1-1948 and that I last saw him alive on 3-1 1948

Immediate cause of death	Duration
Pneumonia	
Abdominal Ca	
Due to Ca of Bowel	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Ca of Sigmoid

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jas A Gartland M. D.
Address Mercy Date signed 3-1-48

VS 150

C60800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C60800

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2301 St. Paul Street
(c) Hospital or institution: 15-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 Bentalou St.
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ---------

3 (a) FULL NAME Bettie C. Price

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Charles H. Price
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr) ----------

8. AGE: Years	Months	Days	If less than one day
About 83	--	---	-- hr. --- min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business -------

FATHER
12. Name Louis E. Brown
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Mary A. Myers
15. Birthplace Baltimore County, Md.

16 (a) Informant Mrs. Harry M. Campbell
(b) Address 5717 Roland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) MAR 2 - 1948 (Date rec'd by registrar) (b) Huntington Wm. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch. 1 1948 at 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 to Mch 1 1948, and that I last saw h[illegible] alive on Mch 1 1948.

Immediate cause of death	Duration
Coronary Thrombosis.	1 hr
Due to Arteriosclerosis	15 yrs
Due to	
Other Conditions Myocarditis Pneumonia (Hypostatic)	2 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harvey S. Plant M. D.
Address 100 E 23rd St Date signed Mch 2 1948

VS 153

060801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 060801

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3401 Greenway

(c) Hospital or institution: 12-V

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3401 Greenway (If rural give location)

(e) Citizen of foreign country? I (Yes or No) If yes, name country

3 (a) **FULL NAME** Catherine J. Malone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widow

6 (b) Name of husband or wife Michael E. Malone

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/1/1866

8. AGE: Years	Months	Days	If less than one day
81	4	-	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Stone Maker

11. Industry or business

FATHER 12. Name John Quinn

13. Birthplace Ireland

MOTHER 14. Maiden Name Do. Not Know

15. Birthplace Ireland

16 (a) Informant Mr. John J. Malone

(b) Address 3401 Greenway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/46 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Old Frederick Road

18 (a) Funeral director D. J. Dahon Sons

(b) Address 1318 Light St.

19 (a) MAR 2- 1946 (Date rec'd by registrar) (b)

WORLD WAR II DECEASED

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1st 1946, at 9:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 26 1946 to March 1st 1946, and that I last saw her alive on March 1st 1946.

Immediate cause of death	Duration
(1) Coronary Thrombosis	4 days
(2) ~~Broncho~~	
Due to -	
Due to - Hypertensive Heart Disease	5 yrs.
Other Conditions - Broncho-Pneumonia (Include pregnancy within 3 months of death)	3 days.

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Earl L. Chambers M. D.

Address 1102 Liberty Heights Ave. Date signed March 1, 1946

X

G60802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC. - 48-04229 160a

Registered No. G60802

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~467 Cummings Ct.~~
(c) Hospital or institution: University Hosp. 11-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 467 Cummings Ct. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country No

3 (a) FULL NAME John T. Wright

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 26, 1948

8. AGE: Years | Months | Days | If less than one day 13 hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Jim Wright

13. Birthplace S.C.

MOTHER 14. Maiden Name Smith, Rosyne

15. Birthplace S.C.

16 (a) Informant Rosyne Wright

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School

18 (a) Funeral director

(b) Address

MAR 2 1948 Commissioner of Health

MAR 2- 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27 1948 at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 26 1948 to Feb. 27 1948 and that I last saw him alive on Feb 27 1948.

	Duration
Immediate cause of death Respiratory failure	
Due to Subarachnoid hemorrhage	
Due to Cerebral trauma	
Other Conditions Cong. Heart lesions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Subarachnoid hemorrhage Patent ductus arteriosus

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert C. Hunter, M.D. M. D.

Address Univ. Hosp. Date signed 2-28-48

VS 150

660803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

Registered No. 660803

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Aberdeen
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac G Giles

3 (b) If veteran, name war: None
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14 - 1904

8. AGE: Years 44 | Months - | Days 17 | If less than one day hr. min.

9. Birthplace Aberdeen Harford Co Md
(Town, county, and state)

10. Usual Occupation Day Laborer
11. Industry or business Rd Ranger

FATHER
12. Name Isaac F Giles
13. Birthplace Aberdeen Md

MOTHER
14. Maiden Name Annie E. Thompson
15. Birthplace Aberdeen Md

16 (a) Informant Mr. James G. Giles
(b) Address Aberdeen Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 6 - 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Aberdeen Md

18 (a) Funeral director Mowery Fanning Stone
(b) Address Aberdeen Md

19 (a) MAR 2 - 1948 (Date rec'd by registrar) (b) Thurlington Williams, M Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1948 at 9 25 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wound of head involving both eyes
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-1-48 at 6:07 P.M.
(b) Where did injury occur? 820 Greenmount Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Firearms

23. Signature [signature] M.D.
Medical Examiner.
Date signed 3-2-48

IVA SPARROW

G60804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G60804

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1826 Mc Henry St
(c) Hospital or institution: 19-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 McHENRY ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Iva Sparrow

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	MARRIED

6 (b) Name of husband ~~or wife~~ LEWIS O
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1870

8. AGE: Years	Months	Days	If less than one day
77	4	21	hr. min.

9. Birthplace DELAWARE (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

MOTHER / FATHER
12. Name JOSEPH ROBINSON
13. Birthplace VA
14. Maiden Name ANNA DELANO
15. Birthplace VA

16 (a) Informant JOHN M SPARROW
(b) Address 1603 W LOMBARD ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MARCH 5 1948 (month) (day) (year)
(c) Cemetery or crematory MT OLIVET
Location FREDERICK RD

18 (a) Funeral director Nancy A Wyse
(b) Address 4131 Edmondson Ave

19 (a) [illegible] 2 1948 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 1st 1948, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948 to Mar 1 1948, and that I last saw her alive on Mar 1 1948.

Immediate cause of death	Duration
(a) Cardiac dilatation	
Due to Ascites	
Due to Chronic Parenchymatous nephritis	
Other Conditions Enterocolitis of long standing (Include pregnancy within 3 months of death)	

Date of operation None
Major findings of operation: ✓
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ (Specify type of place) While at work? ✓
(e) Means of injury ✓

23. Signature Bernard S. French M. D.
Address 379 Greenmount Ave Date signed 3/2/48

VS 3

660805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. 660805

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dba
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass. (b) County
(c) City or town Sommerville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 142 Highland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary E. Stewart
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) June 1888

8. AGE: Years	Months	Days	If less than one day
59	9		hr. min.

9. Birthplace Bennington Vermont
(Town, county and state)
10. Usual Occupation Chief Engineer
11. Industry or business Merchant Marine

FATHER
12. Name Thomas Stewart
13. Birthplace Scotland

MOTHER
14. Maiden Name Mary Fulton
15. Birthplace Ireland.

16 (a) Informant Douglas Stewart
(b) Address 90 S. Main St. Mahanoville

17 (a) Burial (b) Date thereof 3-5-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parklawn Mem.
Location Bennington Vermont

18 (a) Funeral director John L. Miller, Inc.
(b) Address 2430 E. Oliver St.

19 MAR 2 - 1948 (b) Bennington Williamson, Mass.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1948 at 10 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute dilatation of heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl V. Hyden M.D.
Medical Examiner.
Date signed 3-1-48

VS 181

C60806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C60806

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 323 E. Lanvale

(c) Hospital or institution: 12-5

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)

(d) Street No. 323 E. Lanvale St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Margaret - E. Padgett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John T. Padgett

6 (c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.) March 9. 1874

8. AGE: Years 73 | Months 11 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER

12. Name George Blake

13. Birthplace Virginia

MOTHER

14. Maiden Name Susan E. Hart

15. Birthplace Virginia

16 (a) Informant John T. Padgett

(b) Address 323 E. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-3-48 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Baltimore - Md.

18 (a) Funeral director F. B. Wippert & Son

(b) Address 1300 Eutaw Place

19 (a) MAR 2 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 29 1948, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1948 to Feb 29 1948, and that I last saw her alive on Feb 29 1948.

Immediate cause of death Chronic Interstitial Nephritis — Duration several years

Due to

Due to Age

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Mrs Lyd C. Blake

Address Md Ave & Ridg Date signed 3/3/48

VS 190

G60807 BOOKER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a

Registered No. G60807

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Pk. Drive & 31st St.

(c) Hospital or institution: US Marine Hospital 23-3

(d) Length of stay in hospital or inst. (yrs., mos., or days): 12 days

(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County:

(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No.: 1828 Clarkson St.
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Robert Edward Booker

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Wid.

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 2, 1896

8. AGE: Years	Months	Days	If less than one day
51	11 10	28 29	hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER

12. Name: George Booker

13. Birthplace: Balto. Md.

MOTHER

14. Maiden Name: Minerva Grund

15. Birthplace: Balto. Md.

16 (a) Informant: Records

(b) Address: US Marine Hospital

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 9-5-48 (month) (day) (year)

(c) Cemetery or crematory: Woodlawn.

Location: Woodlawn Road

18 (a) Funeral director: J. W. Kenny

(b) Address: 10 S. Fulton Ave.

19 (a) MAR 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1, 1948, at 5:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 18 1948, to Mar. 1 1948, and that I last saw him alive on Mar. 1 1948.

	Duration
Immediate cause of death: Perforated gastric ulcer with peritonitis	3 days
Due to:	
Due to:	
Other Conditions: Atelectasis left lower lobe	Unknown

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury:

23. Signature: John L. Wilson

Address: John L. Wilson, Sr. Surgeon, Clinical Director Date signed 3/2/48

VS 150

X

660808

GM. 117241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH . 13 B

Registered No. 660808

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 23-2

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 25 Days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1609 Hardan CT. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen Webester Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife William Brooks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24-1923

8. AGE: Years 24 | Months 11 | Days 8 | If less than one day hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name John H. Ritis (D)

13. Birthplace MD.

MOTHER

14. Maiden Name Nettie Mae Abott

15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 3-4-48 (month) (day), (year)

(c) Cemetery or crematory Locust Point

Location Brooklyn.

18 (a) Funeral director J. J. McCarey

(b) Address 1505 S. Fort Ave.

19 (a) MAR 2- 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 1 - 1948, at 815 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2 - 6 - 1948 to 3 - 1 - 1948 and that I last saw h alive on 19

Immediate cause of death Pulmonary Tuberculosis FA - Duration 8 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Edmund Beadlam M. D.

Address Balto City Hosp Date signed 1 Mar 48

VS 150

G60809

FLEURY

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. G60809

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lynch & Calhoun St.
(c) Hospital or institution: Franklin Square
(d) Length of stay in hospital or inst. (yrs., mos., or days) 66 days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 Meadow Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George J. Henry

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1892

8. AGE: Years 55 | Months 8 | Days 15 | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER: 12. Name Frederick
13. Birthplace U.S.

MOTHER: 14. Maiden Name Salsbury Tevyes
15. Birthplace Md.

16 (a) Informant Family
(b) Address Same

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 3-4-48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave & Rs.

18 (a) Funeral director Leo P. Carey
(b) Address 80 E. Fort Ave

19 MAR 2- 1948 (Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1, 1948 at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from January 12, 1948, to March 1, 1948, and that I last saw him alive on March 1, 1948

Immediate cause of death	Duration
Congestive heart failure	
Due to Rheumatic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy Rheumatic Heart Disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bobby L. Jones
Address Franklin Square Hosp. Date signed 3/1/48 M. D.

Huntington Williams, M.D.

G60810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC-CG6045 107

G60810

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 10-2

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 733 N. Central Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Hayes.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-6-47

8. AGE: Years	Months	Days	If less than one day
	2	3 4	hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Moses

13. Birthplace Unknown

MOTHER 14. Maiden Name Cuna

15. Birthplace Unknown

16 (a) Informant Friend.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Johns Hopkins Medical School MAR 1 1948

Location Commissioner of Health

18 (a) Funeral director

(b) Address

MAR 2 - 1948 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 - 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1948 to Feb 10 1948, and that I last saw him alive on Feb. 10 1948.

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to Acute Intestinal

Other Conditions Defeciency

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. M. Edmonds M. D.

Address J. Hopkins Hosp Date signed 2-10-48

VS 150

X

C60811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC = C 89506 157E

Registered No. C60811

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5-2
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 287 N. Exeter St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Parker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-18-47

8. AGE: Years Months Days If less than one day hr. min.
45 - -

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Priel

13. Birthplace P

MOTHER 14. Maiden Name Jannie Mae Parker

15. Birthplace md.

16 (a) Informant

(b) Address

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical School MAR 1 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 MAR 2 1948 (b) Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-18-48 at 6.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1 1948 to 2-18-1948
and that I last saw h alive on 2-15 1948

Immediate cause of death Capillary Bronchitis — Duration 16 Days

Due to

Due to

Other Conditions Org. Heart Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Johns Hopkins Date signed 2-19-48

VS 150

107

G60812

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G60812

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 W. Lexington (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1900

8. AGE: Years 48 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

MOTHER - FATHER

12. Name Charlie

13. Birthplace Md.

14. Maiden Name Hanna ?

15. Birthplace Md

16 (a) Informant Samuel Smith

(b) Address

17 (a) ... (Burial, cremation, or removal) (b) Date thereof ... (month) (day) (year)

(c) Cemetery or crematory Johns Hopkins Medical School MAR 2 1948

Location

(a) Funeral director Commissioner of Health

(b) Address

MAR 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26 1948, at 3:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/25 1948, to 2/26 1948, and that I last saw h... alive on 2/26 1948

Immediate cause of death Cardiac Resp Collapse — Duration

Due to Pneumococcus Septicemia — Duration

Due to Chronic Alcoholism — Duration

Due to Diuresis — Duration

Other conditions Cachexia — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. N. Taylor M. D.

Address Redwood & Greene Date signed 2/26/48

VS 159

X

Dr. Brennan

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. C60813

C60813

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3001 Echodale Avenue
(c) Hospital or institution: 27-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3001 Echodale Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul F. Peters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Anna M. Peters

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1885

8. AGE: Years 62 | Months 6 | Days 16 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation salesman

11. Industry or business

MOTHER - FATHER

12. Name Frank Peters

13. Birthplace Germany

14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Mrs. Anna M. Peters

(b) Address 3001 Echodale Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-3-48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Harford Road, 14

19 (a) MAR 2 - 1948 (Date rec'd by registrar) (Transcription from Baltimore, Md.) Registrar

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH February 29 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1947 to Feb 1948 and that I last saw him alive on Feb 28 1948.

Immediate cause of death Cardiac failure — Duration

Due to Anoxia

Due to Severe atrophic emphysema

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. Brennan M. D.

Address 5217 Harford Road Date signed 2-29-48

660814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46M

660814 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3013 Overland Ave
(c) Hospital or institution: 27-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3013 Overland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Valeria Burgess

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/12/1865

8. AGE: Years	Months	Days	If less than one day
82	6	21	hr. min.

9. Birthplace Balt. Md. (Town, county, and state)
10. Usual Occupation Home Keeper
11. Industry or business

FATHER 12. Name Caleb H Burgess
13. Birthplace Baltimore
MOTHER 14. Maiden Name Mary A Holland
15. Birthplace Unknown

16 (a) Informant Sara E B Burgess
(b) Address 3013 Overland Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md
18 (a) Funeral director Wilhoyte & Son
(b) Address 1319 Park Ave
19 (a) MAR 3 - 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1948 at 1 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1947 to March 1 1948
and that I last saw her alive on Feb 26 1948
Immediate cause of death Chronic Anemia — Duration 7 Mos
Due to age
Due to Possible to Gastric Intestinal Malignancy
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation None
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Samuel E Engers M. D.
Address 612 N 40 St Date signed

VS 3

C60815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C60815

GM. 117158 1310

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 5-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 28
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1047 Hillen St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Edward Wright

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Mary (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept, 8 1873

8. AGE: Years	Months	Days	If less than one day
74	5	23	hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Wright (D)
13. Birthplace MD.

MOTHER
14. Maiden Name Catherine Roundtree
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore Md.

18 (a) Funeral director Wilson & Son
(b) Address 1219 E. Coul St.

19 (a) MAR 2 1948 (Date rec'd by Registrar) at [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 1 - 1948, at 6.00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2 - 3 - 1948, to 3 - 1 - 1948, and that I last saw him alive on 3 - 1 - 1948

Immediate cause of death	Duration
Cerebral Thrombosis ?	18 hours
with hemiplegia	
Due to Generalized and Cerebral Arteriosclerosis	?
Due to Uremia with uremic pericarditis due to arteriosclerosis	
Other Conditions Nephrosclerosis	
Bronchopneumonia, bilat	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed 3-1-48

VS 150

G60816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G60816

GU 117266

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 18-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 25 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 52 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD, (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1130 Hollins ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harvey Thomas Bond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Marion Bond
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20 -1891

8. AGE: Years	Months	Days	If less than one day
56	5	12	hr. min.

9. Birthplace MD. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Eddy Bond
13. Birthplace PA.

MOTHER
14. Maiden Name Eleanore Louise Patterson
15. Birthplace PA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/48 (month) (day) (year)
(c) Cemetery or crematory Stewartstown
Location Stewartstown Pa.

18 (a) Funeral director Wilson Conf Co
(b) Address 1219 Cont St

19 MAR 3 1948 (Date rec'd by registrar) Huntingdon Williamsport Pa

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 2 - 1948, at 9.00AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2 - 7 - 1948 to 3 - 2 - 1948, and that I last saw h imalive on 3-2- 1948.

Immediate cause of death: Bronchopneumonia, Bilateral — Duration: days
Due to: Primary Carcinoma of Lungs — months
Due to: Metastatic Carcinoma of 1st Lumbar Vertebra — weeks
Other Conditions: Also 2nd & 3rd Lumbar Vertebra — days
Fracture Pathologic (Antedating death by not more than 3 months)
Date of operation none
Major findings of operation:
of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Josh E. Butterworth M. D.
Address Balt City Hosp. Date signed Mar 2, 48

G60817

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46E

Registered No. G60817

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Sinai Hospital
(b) Street address — Monument & Rutland Ave
(c) Hospital or institution: 13-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) — 40 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State — Md (b) County
(c) City or town — Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. — Emersonian Apts (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME — William L. Sacks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — Nov, 6, 1894

8. AGE: Years	Months	Days	If less than one day
53	3	25	16 hr. min.

9. Birthplace — Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business — Accounting Business

FATHER
12. Name — Aaron Sacks
13. Birthplace — Russia

MOTHER
14. Maiden Name — Goldie Crockin
15. Birthplace — Russia

16 (a) Informant — Harry M Sacks
(b) Address — 2206 Sulgrave Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 3, 1948 (month) (day) (year)
(c) Cemetery or crematory — Bnai Israel Cemetery
Location — Southern Ave

18 (a) Funeral director — Sol Levinson & Bros
(b) Address — 1124-1126 W North Ave

19 (Date received by registrar) MAR 3 1948 (Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH — March 2 1948, at 1:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-20 1948 to 2 March 1948, and that I last saw h[illegible] alive on 2 March 1948

Immediate cause of death — Cardio-Respiratory Failure — Duration

Due to — Carcinoma of Hepatic Flexure c generalized metastasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation — Oct 1947

Major findings of operation: Carcinoma Hepatic Flexure

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature — Rud H. Lerman, M.D.
Address — Sinai Hospital Date signed — 2 March 1948

VS 150

X

G60818

BALTIMORE CITY HEALTH DEPARTMENT ✓ X G60818

CERTIFICATE OF DEATH 157 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Green Sts.
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Monkton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Henderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-28-48

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation child

11. Industry or business none

FATHER
12. Name Albert Griffith Henderson
13. Birthplace Harford Co Md

MOTHER
14. Maiden Name Pauline Mae Craley
15. Birthplace Spring Grove Penn

16 (a) Informant Albert G. Henderson
(b) Address Monkton, Md

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Mar - 3 - 48 (month) (day) (year)
(c) Cemetery or crematory Hereford Baptist
Location Monkton Md

18 (a) Funeral director Howard L. Markline
(b) Address Wetzel Hall Md

19 (a) MAR 3 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 2 1948, at 12.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1-1948 to 3-2-1948, and that I last saw h.r. alive on 3-2-1948.

Immediate cause of death	Duration
cardiac	
resp. embarrassment	
Due to Spina bifida	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John H. Rowe M. D.
Address Univ. Hosp. Date signed 3-4-48
Balto, Md.

VS 150

X

GG0819 Osler-3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30E

GG0819 Registered No. 4[illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 6-4
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 229 N Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ethel Wallington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Albert Wallington

6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) 1915

8. AGE: Years: 33 year | Months | Days | If less than one day: hr. min.

9. Birthplace: Winnsboro S. C. (Town, county, and state)

10. Usual Occupation: Domestic

11. Industry or business

FATHER
12. Name: Henry Suber
13. Birthplace: South Carolina

MOTHER
14. Maiden Name: Lavinia Knapp
15. Birthplace: South Carolina

16 (a) Informant: Albert Wallington
(b) Address: 229 N. Wolfe St JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-1948 (month) (day) (year)
(c) Cemetery or crematory: St. Matthews Cem
Location: Dawkins S. C.

18 (a) Funeral director: Elroy O. Wilson
(b) Address: 1000 Bentley ave

19 MAR 3- 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/1 1948 at 900 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1948 to 3/1 1948 and that I last saw her alive on 3/1 1948.

Immediate cause of death: Coronary Occl.

Due to: Pulm. embolus

Due to: ? RHD; ? Syph. H.D.

Other Conditions: Autopsy.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: M. Hurock M. D.

Address: [illegible] Date signed 3-4-48

VS 150

C60820

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. C60820

111c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2556 Mace St
(c) Hospital or institution: 12-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2556 Mace St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lurania Epps Chatman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John Chatman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 71 | Months | Days | If less than one day hr. min.

9. Birthplace Dinwiddie Co, Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Epps
13. Birthplace Va.

MOTHER
14. Maiden Name Virgie Ann Epps.
15. Birthplace Va.

16 (a) Informant Hannah Harris
(b) Address 2556 Mace St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn, Md

18 (a) Funeral director Elroy Davidson
(b) Address 1000 Brantly Ave

19 MAR 3 1948 (Date rec'd by registrar) (b) [illegible] (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1948, at 8:25 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 29 1948 to Mar 1 1948 and that I last saw her alive on Feb 29 1948.

	Duration
Immediate cause of death Pulmonary Edema	Undet.
Due to Right sided heart failure	over
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at: M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Garland Linthicum M. D.
Address 90 W. Franklin Date signed 3-2-48

US 150

C60821 N

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. C60821

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Raynor & Dukeland Aves.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days): 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Baltimore
(c) City or town: Raspeburg (If outside city or town limits, write RURAL and give town)
(d) Street No.: 5401 McCormick Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country:

3 (a) FULL NAME: George D. Lambright

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 9th, 1864

8. AGE: Years	Months	Days	If less than one day
83	2	22 23	hr. min.

9. Birthplace: Harford County, Md. (Town, county, and state)

10. Usual Occupation: Truck Farmer

11. Industry or business:

FATHER
12. Name: John Lambright
13. Birthplace: Harford County, Md.

MOTHER
14. Maiden Name: Martha
15. Birthplace: Unknown

16 (a) Informant: Mr. John M. McCormick
(b) Address: 5401 McCormick Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof: 3/5/48 (month) (day) (year)
(c) Cemetery or crematory: Friendship
Location: Harford County, Md.

18 (a) Funeral director: Lasvaka Funeral Home
(b) Address: 7401 Belair Road

MAR 3 - 1948 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2 1948, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from February 27 1948 to March 2 1948, and that I last saw h[illegible] alive on March 2 1948.

Immediate cause of death	Duration
Cardio-respiratory failure.	
Due to cerebral vascular accident	
Due to Arteria-sclerotic vascular disease	
Other Conditions Hypertensive c.v.d.	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Leonard Tucker M.D.
Address: Pikesville Md. Date signed: 3-2-48

VS 150

Neil Hoop X

G60822

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G60822

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2812 Clifton Park Terrace
(c) Hospital or institution: S-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2812 Clifton Park Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph A. Barnes. Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married

6 (b) Name of husband or wife Mary Barnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12 1870

8. AGE: Years 76 (77) | Months 9 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph a. Barnes
13. Birthplace Baltimore

MOTHER
14. Maiden Name Dalie Weaver
15. Birthplace Baltimore

16 (a) Informant Mrs Mary Barnes
(b) Address 2812 Clifton Park Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-4-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Jos. J. Henderson
(b) Address 3011 Eutaw Ave Huntington Williams Mgr

MAR 3 - 1948 (Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/29/48 19 at 10:30 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Generalized Arteriosclerosis
(Arteriosclerotic Cardiovascular Disease)

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D. Medical Examiner.
Date signed 2/29/48

X

G60823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310

Registered No. G60823

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2612 FRANCIS ST.

(c) Hospital or institution: 13-3

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 2612 FRANCIS ST. (If rural give location)

(e) Citizen of foreign country? — (Yes or No) If yes, name country —

3 (a) **FULL NAME** ELLA MAY WHITCOMB

3 (b) If veteran, name war NO

3 (c) Social Security Account No. NO

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife JOHN W

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) FEB 16, 1889

8. AGE: Years 59 | Months 0 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace CARROLL CO., MD. (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER

12. Name DAVID H. LAWSON

13. Birthplace Pa.

MOTHER

14. Maiden Name SARANDA REDDING

15. Birthplace CARROLL CO., MD.

16 (a) Informant JOHN W. WHITCOMB (HUSBAND)

(b) Address 2612 FRANCIS ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/4/48 (month) (day) (year)

(c) Cemetery or crematory STONE CHAPEL

Location BALTO CO., MD.

18 (a) Funeral director WM J. TICKNER & SONS

(b) Address BALTIMORE, MD.

19 (a) (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/1/48 —19— at 6 05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 25 1947 to Mar. 1 1948, and that I last saw h[illegible] alive on Mar. 1 1948.

Immediate cause of death ..... Duration

Chr. Myocarditis — 1944

Due to

Due to Chr. Parenchymatous nephritis — 1944

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul Brown

Address 1663 N. North ave Date signed 3/2/48 (M.D.)

X

G60824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73a

G60824 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1642 W. North Ave
(c) Hospital or institution: W-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 66 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1642 W. North Ave
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Maximillan Mannel

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Mary Cecilia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8, 1881

8. AGE: Years	Months	Days	If less than one day
66	5	28	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Shoemaker
11. Industry or business Self.

FATHER
12. Name Charles Mannel
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Slack
15 Birthplace Germany

16 (a) Informant Mrs. Mary C. Mannel
(b) Address 1642 W. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/48 (month) (day) (year)
(c) Cemetery ~~crematory~~: Western
Location Baltimore, Md.

18 (a) Funeral director Wm. T. Tickner & Sons
(b) Address Baltimore, Md.

19 (a) [illegible] (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/1/48 19 , at 7 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1948 to Mar 1 1948 and that I last saw him alive on Mar 1 1948.

Immediate cause of death	Duration
Pernicious Anemia	4 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. William Frey M.D.
Address 1928 Penna Ave Date signed 3/2/48

VS 150

660825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

660825 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 704
(c) Hospital or institution: West Balto Gen'l
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 65 Franklintown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie L. Dorsey

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife: Frank B. Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb 24, 1876

8. AGE: Years	Months	Days	If less than one day
72	0	7	hr. min.

9. Birthplace: Baltimore, MD.
(Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: —

FATHER
12. Name: Harry Anderson
13. Birthplace: Cockeysville, MD

MOTHER
14. Maiden Name: Mary Louise Miller
15. Birthplace: Baltimore, MD.

16 (a) Informant: Hosp. Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/48 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Balto. Co. MD.

18 (a) Funeral director: Wm. J. Tickner & Sons
(b) Address: Baltimore, MD.

19 (a) 3-1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-1- 1948, at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-28 1948 to 3-1 1948, and that I last saw her alive on 3-1 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertensive Cardio-	
Due to Vascular Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: W.W. Bindeman M.D.
Address: W. Balto. Md. Hosp. Date signed 3-2-48

VS 150

L-60826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

L-60826 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N Carey St
(c) Hospital or institution: Good Samaritan Home 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 218 E Cross St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph F. Garland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 7 1874

8. AGE: Years	Months	Days	If less than one day
73	7	—	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Joseph Garland
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Kane
15. Birthplace Ireland

16 (a) Informant Mrs Mary Welsh
(b) Address 1170 Riverside Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-4-1948 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. G. Co. Md.

18 (a) Funeral director Flynn & Flemming
(b) Address 1426 Light St

19 (a) 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1948 at 10 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 1948 to March 1 1948, and that I last saw h[illegible] alive on March 1 1948.

Immediate cause of death	Duration
Malnutrition	6 Months
Due to Arteriosclerosis	
Due to	
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hale Swperrier M. D.
Address 1348 Bloodst. Date signed

VS 150

X

660827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1318

Registered No. 660827

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3316 FOSTER AVE.
(c) Hospital or institution: - - - NONE - - 26-11
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3316 FOSTER AVE. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country — — — —

3 (a) FULL NAME CAROLINE VOGEL

3 (b) If veteran, name war —

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOWED

6 (b) Name of husband or wife JOHN VOGEL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1 - 11 - 1872

8. AGE: Years	Months	Days	If less than one day
76	1	19	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business HOME

FATHER
12. Name BERNARD RETHMANN
13. Birthplace BALTO.

MOTHER
14. Maiden Name ELIZABETH BUSHMAN
15 Birthplace BALTO.

16 (a) Informant ADAM VOGEL - SON
(b) Address 3310 FOSTER AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3 - 5 - 48 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director LILLY + ZEILER INC.
(b) Address 403 S. WOLFE ST.

19 (a) MAR 3 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 1, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 - 1 1947 to 3 - 1 - 1948. and that I last saw h[illegible] alive on 2 - 1 - 48

Immediate cause of death	Duration
Arteriosclerotic C.V. Disease.	2-1-47
Chr. Glomerular Nephritis	2-2-48.
Due to Intracranial Failure	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Schumunk M. D.
Address 842 S. East Ave Date signed 3-3-48

VS 150

G60828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G60828

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 315 days
(e) Length of stay in Baltimore (yrs., mos., or days) 315 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mass. (b) County:
(c) City or town: Boston
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 415 Hanover St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Jose Deamorin

3 (b) If veteran, name war: --

3 (c) Social Security Account No. 180-12-9771

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Wid.

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 8, 1880

8. AGE: Years	Months	Days	If less than one day
68	1	19	hr. min.

9. Birthplace: Portugal (Town, county, and state)
10. Usual Occupation: Fireman
11. Industry or business: Seafarer

FATHER
12. Name: Antonie Deamorin
13. Birthplace: Portugal

MOTHER
14. Maiden Name: Mary Amalene
15 Birthplace: ? Portugal

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 3 48 (month) (day) (year)
(c) Cemetery or crematory: Sacred Heart
Location: German Hill Rd.

18 (a) Funeral director: Lilly and Zeiler, Inc.
(b) Address: 403 S. Wolfe St.

19 (a) MAR 3 - 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 27 19 48, at 9:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 18 19 47 to Feb. 27 19 48 and that I last saw h im alive on Feb. 27 19 48.

Immediate cause of death: Carcinoma cardias end of stomach — Duration: 2 yrs.

Due to:

Due to:

Other Conditions: Bronchopneumonia — 4 days

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed 3/2/48

VS 150

660829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

660829 Registered No.

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or Institution: St. Joseph's 2-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2022 Bank (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country —

3 (a) FULL NAME Mary Margaret Connelly

3 (b) If veteran, name war —

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1889

8. AGE: Years	Months	Days	If less than one day
58	3 4	12	hr. — min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation MERCHANT

11. Industry or business Sea Food

MOTHER / FATHER

12. Name Martin Connelly

13. Birthplace Md.

14. Maiden Name Anna Gast

15. Birthplace Md.

16 (a) Informant Sister: Mrs. Helen Tucker

(b) Address 1605 N. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-48 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart

Location German Hill Rd.

18 (a) Funeral director Lilly & Zeiler Inc

(b) Address 402 S. Wolfe St.

19 (a) 3-3-1948 (Date rec'd by registrar) (b) Huntington Whitehurst M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1, 1948 19 , at 4:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 23, 1948 to Mar. 1, 1948, and that I last saw her alive on Mar. 1, 1948.

Immediate cause of death	Duration
Cardio Respiratory Failure	
Due to Broncho-pneumonia	
Due to Peritonitis	
Other Conditions mesenteric hemorrhage	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy Peritonitis, pneum, hemorrhage

PHYSICIAN

Underline the cause to which death should be charged. Statis-

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Whitehurst M.D.

Address 1400 Caroline Date signed 3/2/48

VS 150

660830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82

Registered No. 660830

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 12-6
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2504 St Paul St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah P. Athey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-5-1887

8. AGE: Years 61 | Months 1 | Days 28 | If less than one day: hr. min.

9. Birthplace: New Jersey (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Thomas Pulham
13. Birthplace Ireland

MOTHER
14. Maiden Name Jane Bevan
15. Birthplace England

16 (a) Informant Dr. Henry B. Athey
(b) Address 2504 St Paul [illegible] HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 4/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3601 Frederick Ave

18 (a) Funeral director John O. Mitchell Home
(b) Address 1900 Eutaw Place

19 (a) MAR 3 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1948 at 4:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-21- 1948 to 3-2- 1948
and that I last saw h[illegible] alive on 3-2 1948.

Immediate cause of death	Duration
Respiratory failure	
Due to Bulbar paralysis	2 mos.
Due to Herniation of cerebellum through foramen magnum & cerebral compression	
Other Conditions Rheumatoid arthritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Admitted [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. E. Markley M. D.
Address Johns Hopkins Hosp. Date signed 3/2/48

VS 150

X

G60831

BALTIMORE CITY HEALTH DEPARTMENT

BC-48-04568 CERTIFICATE OF DEATH 160c

Registered No. G60831

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address N. Broadway

(c) Hospital or institution: Church Home & Hospital 28-3

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs

(e) Length of stay in Baltimore (yrs., mos., or days) —"

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5104 Witherspoon Rd (Number if any must be given)

WETHERSFIELD

(e) Citizen of foreign country? (Yes or No)

If yes, name country —

3 (a) FULL NAME Baby Boy Naylor

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	S.

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 3, 1948

8. AGE: Years	Months	Days	If less than one day
—	—	—	10 hr. 30 min.

9. Birthplace Church Home & Hospital (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

MOTHER

12. Name Mrs. Caroline Dunham Naylor

FATHER

13. Birthplace Md.

MOTHER

14. Maiden Name Caroline Dunham

15. Birthplace Va.

16 (a) Informant Mrs. Caroline Naylor

(b) Address 5104 Witherspoon Rd. Balt. Md.

17 (a) cremation (Burial, cremation, or removal) (b) Date thereof 3/4/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location 3801 Frederick Ave.,

18 (a) Funeral director Mitchell, John A. & Sons, Inc.

(b) Address 1900 Eutaw Place

19 (a) 3 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1948, at 8 30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10:00 A.M. 3/2 1948 to 7:30 P.M. 3/2 1948, and that I last saw him alive on 3/2 1948.

Immediate cause of death Atelectasis for 1

following birth by

Due to Caesarean Section for

concealed hemorrhage of the

Due to uterus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

Duration
10 hrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Richard M. Garrott M.D.

Address Church Home Hosp. Date signed 3 Mar 48

VS-150

G60832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G60832

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16-S. Tremont Road.
(c) Hospital or institution: 28-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 16-S. Tremont Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Bissett.

3 (b) If veteran, name war: None
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed.

6 (b) Name of husband or wife George Bissett.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26-1865

8. AGE: Years	Months	Days	If less than one day
82	7	3	hr. min.

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual Occupation Retired Housewife.
11. Industry or business

FATHER
12. Name Conroy.
13. Birthplace Ireland.

MOTHER
14. Maiden Name Markham.
15. Birthplace Ireland.

16 (a) Informant Charles Bissett.
(b) Address 16-S. Tremont Road.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 3/3/48. (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore-Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 3512-Frederick Ave.

MAR 2 1948 (Date rec'd by registrar) Huntingtown, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 29- 1948, at 12.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6 1947, to 2/29 1948
and that I last saw her alive on 2/29 1948

Immediate cause of death: Cerebral Arteriosclerosis — Duration: 4 yr.
Due to:
Due to:
Other Conditions: Myocardial degeneration — 3 day
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Theller
Address 14 W. Pleasant Date signed 3/1/48 (M) (D)

V S 15b

97

G60833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164a

Registered No. G60833

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15-11
(c) Hospital or institution: Biltimore Hotel - room 526
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3508 Grantley Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LOUIS BLANKS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years 44 | Months | Days | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Cocktail Lounge

11. Industry or Business

FATHER
12. Name Peter
13. Birthplace Russia

MOTHER
14. Maiden Name Mary
15. Birthplace Russia

16 (a) Informant Minnie Blanks
(b) Address 3508 Grantley Road

17 (a) Burial (Burial, cremation, or removal) (b) Date there 3-3-48 (month) (day) (year)
(c) Cemetery or crematory
Location Rehoboth Memory Lane

18 (a) Funeral director Jack Kedris Inc
(b) Address 7400 Eastern Place

19 (a) 3/3/48 (Date rec'd by registrar) (b) Clinton Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1948, at 8:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Strangulation

Due to Hanging

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 2/48 8 P.M.
(b) Where did injury occur? Biltimore Hotel
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No
(d) Means of injury Hanging by belt

23. Signature [signature] M.D. Medical Examiner.
Date signed 3-3-48

C60834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 190

Registered No. C60834

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2121 Division St.
(c) Hospital or institution: 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2121 Division St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Matthew Randolph

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 23 1906

8. AGE: Years	Months	Days	If less than one day
41	2	5	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name Frank Randolph
13. Birthplace Va

MOTHER
14. Maiden Name Katie Stovall
15. Birthplace Va

16 (a) Informant Matthew Randolph Nephew
(b) Address 2121 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 3 48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A A County

18 (a) Funeral director Mrs Pott Edwards
(b) Address 1129 N Carlton St.

MAR 3 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 1948, at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/26/48 to 2/28/48 and that I last saw h alive on 19

Immediate cause of death	Duration
Pulmonary Embolism	
Due to Frost Bite Lt Leg	2 yrs
Due to	
Other Conditions	2/28/48

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H Duke Boone M. D.
Address 113 E Fayette St Date signed 3/1/48

C60835

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 131a

C60835
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1617 Harlem ave
(c) Hospital or institution: 163
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 — Harlem ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lizzie Morris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9 — 14 — 1873

8. AGE: Years	Months	Days	If less than one day
54	— 5	— 14	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

MOTHER / FATHER

12. Name ?

13. Birthplace ?

14. Maiden Name ?

15. Birthplace ?

16 (a) Informant William H. Gross

(b) Address 501 Cumberland st

17 (a) Burial (b) Date thereof 3-3-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Mt. Cutburen

18 (a) Funeral director William A. Jackson

(b) Address 916 Penna ave

19 (a) Date Received by Local Registrar (Signature) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 1948, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 1948 to 2/28 1948, and that I last saw h[illegible] alive on 2/16 1948.

Immediate cause of death	Duration
Chronic Cardio-vascular Renal disease.	2 yrs
Due to Uremic Poisoning	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address 610 Cathedral

660836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 660836

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12-6
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d
(e) Length of stay in Baltimore (yrs., mos., or days) a

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town ~~2908~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 Cresmont av.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Lucy Hopkinson

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex F | 5. Color or race W. | 6 (a) Single, married, ~~widowed~~, or divorced.

6 (b) Name of husband or wife B. Merrill Hopkinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9. 1863

8. AGE: Years 84 | Months 5 | Days 23 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wm Lewis
13. Birthplace Md.

MOTHER
14. Maiden Name Sibbie J Mac Ferran
15. Birthplace Md.

16 (a) Informant Mrs Elmer Perkins
(b) Address 2908 Cresmont ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 4 1948 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location North Ave & Greenmount ave

18 (a) Funeral director John Oldfield Sons
(b) Address 1400 Eutaw Place

19 (a) Mar 1948 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 2 1948, at 1035 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-22 1948, to 3-2 1948 and that I last saw h alive on 3-2 1948.

Immediate cause of death Embolism — Duration
Due to Phlebothrombosis
Due to Fracture L st femur
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 3-1-48.
Major findings of operation: Fracture - intertrochanteric rt hip
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 12/6
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Feb 20 at 4 M
(c) Where did injury occur? Baltimore Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Fall - Injured r hip & fell to floor

23. Signature Howard J. Moreis, M.D.
Address Univ. Hosp. Date signed 3-24-48

VS 150

Howard J. Moreis, M.D. X

C60837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

Registered No. C60837

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15-1
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1438 Parrish St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Clayton Nutt

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Nellie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/6/19??

8. AGE: Years 35 | Months 4 | Days 25 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Geater Nutt
13. Birthplace Va

MOTHER
14. Maiden Name Hannah Bee
15. Birthplace Va

16 (a) Informant Hannah Nutt
(b) Address 712 N. Bruce St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md.

18 (a) Funeral director Geo. H. Olson
(b) Address 1303 Presstman St

19 MAR 3 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1948, at 10:20 PM

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Stab-wound of stomach.
Peritonitis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-28-48 at 1:45 P.M.
(b) Where did injury occur? Parrish & Lawrence St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Sharp Instrument

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 3-2-48

VS 151

To be a G60838 BALTIMORE CITY HEALTH DEPARTMENT ✓ G60838
by Medical Examiner **CERTIFICATE OF DEATH** 186a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 14-3
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2002 Division St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Ada Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/16/61

8. AGE: Years	Months	Days	If less than one day
86	10	14/16	hr. min.

9. Birthplace Newburg N. Y. (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER 12. Name
FATHER 13. Birthplace
MOTHER 14. Maiden Name
MOTHER 15. Birthplace

16 (a) Informant James J. Williams
(b) Address 2002 Division St Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-4-1948 (month) (day) (year)
(c) Cemetery or crematory National Cemetery
Location Fairfield Md

18 (a) Funeral director George T. Gilson
(b) Address 1765 Druid Hill Ave

MAR 8 1948 (Date) (b) Registrar
Huntington Avenue, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/2 1948, at 1.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/13 1948 to 3/2 1948 and that I last saw her alive on 3/2 1948

Immediate cause of death Uremia — Duration 4 days

Due to Fracture of neck of right femur — 20 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2/17/48

Major findings of operation: Fracture of neck of rt femur. Steinmann pin placed in rt tibia

Autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident 14-3
(b) Date of occurrence 2/11/48 at M
(c) Where did injury occur? Baltimore Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Slipped on steps & fell to ground

23. Signature O. W. Hyslop, M.D.
Address Provident Hosp Date signed 3/2/48

Howard J. Saunders, M.O.X

VS 190

G60839
B.C. 48-02247

BALTIMORE CITY HEALTH DEPARTMENT ✓ G60839
CERTIFICATE OF DEATH 182a
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17-1
(c) Hospital or institution: Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) One
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 924 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Lee Payne Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/24/48

8. AGE: Years - | Months 5 Mths | Days 8 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Wm. Payne
13. Birthplace Va.

MOTHER 14. Maiden Name Mercy A. Brown
15. Birthplace Va

16 (a) Informant James Wm. Payne
(b) Address 924 - Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 E. Druid Hill Ave.

19 (a) MAR 3 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1948 at 12 50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Mechanical Suffocation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-29-48 at 17/1 P.M.(?)
(b) Where did injury occur? 924 Druid Hill Ave
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No Probably suicide
(d) Means of injury [illegible]

23. Signature [illegible] M.D. Medical Examiner
Date signed 3-1-48

VS 151

X

660840

BALTIMORE CITY HEALTH DEPARTMENT ✓ 660840 Registered No.

CERTIFICATE OF DEATH 13/a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 Park Ave
(c) Hospital or institution: 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Nolan
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1875

8. AGE: Years	Months	Days	If less than one day
73	-	23	24 hr. min.

9. Birthplace Phila, Penna. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Nolan
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary F. Dailey
15. Birthplace ?

16 (a) Informant Philip B. Smith
(b) Address 6303 Blackburn Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-4-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director John A. Moran
(b) Address 3600 E. Balt. St.

19 (a) MAR 8 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 1, 1948 at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from OCT. 20 1947 to MAR 1, 1948 and that I last saw her alive on FEB. 29, 1948

Immediate cause of death	Duration
Hypertension	
Due to Cardio-vascular-Renal disease	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lloyd L. Taylor M. D.
Address 3902 Greenmount Ave Date signed Mar. 8, 1948

Countersigned Huntington Williams M.D. Registrar

VE 150

X

G60841

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 93a

G60841
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1310 Ballard Way
(c) Hospital or institution: 26-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 Ballard Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A. C. Jenkins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Annie M. Jenkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 12, 1875

8. AGE: Years	Months	Days	If less than one day
72	6	17	hr. min.

9. Birthplace W. Va.
(Town, county, and state)
10. Usual Occupation House Painter.
11. Industry or business Retired.

FATHER
12. Name Louis D. Jenkins.
13. Birthplace Va

MOTHER
14. Maiden Name Cordilia Peacher.
15. Birthplace ?

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof Mar. 4, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden.

18 (a) Funeral director Paul E. Lehmanowsky Jr.
(b) Address 2615-17 Chestnut Ave.

MAR 3 1948 Huntington Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 29, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1948 to Feb 29 1948, and that I last saw him alive on Feb. 26 1948.

	Duration
Immediate cause of death Myocarditis, acute	2 wks.
Due to Bronchial asthma	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David N. Andrew M.D.
Address Keyser's Ld Date signed 3/2/48.
Glendale 22 Md

VS 150

G60842

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G60842
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 868 Park Avenue
(c) Hospital or institution: 11-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 868 Park Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Lyda Allen Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Eugene F. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6-1875

8. AGE: Years	Months	Days	If less than one day
72	6	27	hr. min.

9. Birthplace Rockingham, Virginia (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Louis Allen
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Alsop
15. Birthplace Unknown

16 (a) Informant Miss Katharine Smith
(b) Address 868 Park Avenue

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof March 3-1948 (month) (day) (year)
(c) Cemetery or crematory Shenandoah
Location Shenandoah, Virginia

18 (a) Funeral director Burgee Funeral Home
(b) Address 363 Halls Road

MAR 3 - 1948 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1948, at 12-20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1948 to March 2 1948 and that I last saw her alive on March 2 1948.

Immediate cause of death: Acute dilation of the heart
Due to: hypertension
Due to: myocarditis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas S. Bowyer M. D.
Address Med Arts Bldg Date signed

VS 150

X 3/3/48

G60843 ✓ G60843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 309

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 27-14
(b) Street address Madison St. & Linden Ave.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 423 Wingate Rd #10 (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Rev. John Henry Von Dreele

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ora Davis Von Dreele
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 11-1885
8. AGE: Years 63 | Months — | Days 21 | If less than one day hr. min.
9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Medical Doctor
11. Industry or business

FATHER
12. Name John H. Von Dreele
13. Birthplace Germany

MOTHER
14. Maiden Name Katharina Lehr
15. Birthplace Germany

16 (a) Informant Mrs. Ora Davis Von Dreele
(b) Address 423 Wingate Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 5-1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) 1948 (Date rec'd by Registrar) (b) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 Mar 19 48, at 355 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 29 Feb 1948 to 2 Mar 1948 and that I last saw him alive on 2 Mar 1948

Immediate cause of death	Duration
Rupture of aneurysm of abdominal aorta	
Due to Arteriosclerotic cardio-vascular disease	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Allan Spicer

Address Md. Gen. Hosp. Date signed 2 Mar 48 M. D.

G60844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

G60844

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2836 St. Paul St

(c) Hospital or institution: **** 12-6

(d) Length of stay in hospital or inst. (yrs., mos., or days) **

(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto. City

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2836 St. Paul St. (If rural give location)

(e) Citizen of foreign country? **** no (Yes or No) If yes, name country

3 (a) FULL NAME Howard G. Bishop

3 (b) If veteran, name war ***

3 (c) Social Security Account No. ****

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Bertha Knapp Bishop

6 (c) If alive, give age *** years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1869

8. AGE: Years	Months	Days	If less than one day
78 80	2	24	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Retired Chemical & Industrial Engineer

11. Industry or business

FATHER

12. Name Wm. T. Bishop

13. Birthplace Maryland

MOTHER

14. Maiden Name Sarah Elizabeth German

15. Birthplace Maryland

16 (a) Informant Gordon K. Bishop

(b) Address 175W. 96th. St., N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Maryland

18 (a) Funeral director H.W. Mears & Son

(b) Address 805 N. Calvert St.

MAR 2 1948 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1948, at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from the 1947 to March 2 1948, and that I last saw h[illegible] alive on March 2 1948

Immediate cause of death: Cerebral Hemorrhage

Due to: Chronic Nephritis + Cerebral Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 30 years

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place; in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Herbert M Foster M. D.

Address 24 24 St. Paul Date signed March 2-48

X

G60845 BALTIMORE CITY HEALTH DEPARTMENT G60845

CERTIFICATE OF DEATH 48a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4-2
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 923 S. Fremont
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche (Mair) O'Brien

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife James O'Brien (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years 45 | Months | Days | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Joyner
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Marie Edwards
(b) Address 2228 W. Baltimore St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/3/48 (month) (day) (year)
(c) Cemetery or crematory Portsmouth
Location Portsmouth Va.

18 (a) Funeral director Wilson & Dye
(b) Address 1294 Scott St

19 1948 (Date rec'd by registrar) Washington Wilkinson, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1948, at 8:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Uremia

Due to hydronephrosis, bilat.

Due to carcinoma of cervix

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl V. Royster M.D.
Medical Examiner.
Date signed 3-2-48

VS 151

G60846 ✓ X G60846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 83B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 23 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 21 PORTSHIP RD. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA ELIZABETH DAVIS (MACKEY)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife JAMES TALLIE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/12/96

8. AGE: Years	Months	Days	If less than one day
52	8	19	hr. min.

9. Birthplace W. VA. (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name A-J Mackey
13. Birthplace W. Va.

MOTHER
14. Maiden Name Ellen O'Neill
15. Birthplace Ireland

16 (a) Informant James J. Davis
(b) Address Rundale Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore Md

18 (a) Funeral director Wilson Parker
(b) Address 1319 Eutaw St

MAR (c) 1948 (Date rec'd by registrar) Huntington Williams Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 1 1948 at 6 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/27 1948 to 3/1 1948, and that I last saw her alive on 3/1 1948.

Immediate cause of death RESPIRATORY FAILURE

Due to CEREBRAL THROMBOSIS

Due to HYPERTENSION - ESSENTIAL

Other Conditions Bronchopneumonia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry J. Houska M. D.
Address St. Jos. Hosp. Date signed 3/1/48

X

Dr Bagley 1225 N Calvert St

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G60847 ✓ G60847 Registration No. 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3810 Fenchurch Rd

(c) Hospital or institution: 12-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3810 Fenchurch Rd (If rural give location) FENCHURCH

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cora A Rhine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 24 1861

8. AGE: Years 87 Months 1 Days 11 If less than one day hr. min.

9. Birthplace Milford Indiana (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Montgomery

13. Birthplace Ga

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Arthur D Callow

(b) Address 3810 Fenchurch Rd

17 (a) Burial Summit (Burial, cremation, or removal) (b) Date thereof 3/4/48 (month) (day) (year)

(c) Cemetery or crematory Glen Haven

Location Harrison Ohio

18 (a) Funeral director Tillman & Son Inc

(b) Address 1217 E Fort St

(a) 3-3-1948 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1948, at 3:47 M

21. I certify that death occurred on the date above stated; that I attended deceased from — 19 to — 19 —, and that I last saw h alive on dead 3/2 1948.

Immediate cause of death Acute Myocardial failure — Duration 7

Due to Advanced arterio sclerosis

Due to Chr. nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Francis L. Bagley

Address 1225 N. Calvert St. Date signed 3/3/48

VS 150

X

G60848

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

X ✓ G60848 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 24 days

2. USUAL RESIDENCE OF DECEASED:
(a) State NY (b) County
(c) City or town Bronx
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1025 Tiffany St.
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Equador

3 (a) FULL NAME Gregorio Espinosa

3 (b) If veteran, name war --

3 (c) Social Security Account No. 086-10-4766

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1900

8. AGE: Years 47 | Months 10 | Days 15/16 | If less than one day hr. min.

9. Birthplace Equador
(Town, county, and state)

10. Usual Occupation AB seaman

11. Industry or business Seafarer

FATHER
12. Name Pedro Espinoza
13. Birthplace Equador

MOTHER
14. Maiden Name Auga ?
15. Birthplace Equador

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Removal (b) Date thereof 3/6/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location New York City

18 (a) Funeral director William Cook Inc
(b) Address 1217 61 Pave St

19 (a) 1948 (b) Huntington Williams Mar
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1948, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 6 1948 to Mar. 1 1948, and that I last saw him alive on Mar. 1 1948.

	Duration
Immediate cause of death Sarcoma, type undetermined with metastasis to right groin and both lungs	Unknown
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 3/2/48

VS 150

G60849

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G60849

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland W.
(b) Street address 704 Lexington Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 704 West Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George L CHRISTNER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Katherine Ohler

6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) July 7, 1916

8. AGE: Years	Months	Days	If less than one day
31	7	26	hr. min.

9. Birthplace Gareth, Pa. (Town, county, and state)

10. Usual Occupation Welder + burner

11. Industry or business Shipyard

FATHER
12. Name Franklin Christner
13. Birthplace Pa

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Pa

16 (a) Informant Mrs Katherine Ohler Christner
(b) Address 704 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/48 (month) (day) (year)
(c) Cemetery or crematory Bridgeview.
Location Salis Pa.

18 (a) Funeral director John F Dennydue
(b) Address 711 Light St.

19 (a) MAR 4 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-2- 1948 at 7 40 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis.
Acute Vedema of lungs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 3/4/48

VS 181

660850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 660850

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2410 Ashland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Dudek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Frances Dudek

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Bellevue (Town, county, and state)
10. Usual Occupation Cabinet Worker
11. Industry or business Ship Building

FATHER
12. Name Joseph Dudek
13. Birthplace Bohemia

MOTHER
14. Maiden Name Not known
15. Birthplace Bohemia

16 (a) Informant Marie Curry
(b) Address Havre de Grace R.D. 2

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 4-4-48 (month) (day) (year)
(c) Cemetery or crematory Oakhill
Location Baltimore Md

18 (a) Funeral director Frank Crockson
(b) Address 900 N. Eden St

19 (a) APR 4 1948 (Date rec'd by Local Reg.) (b) Signature of Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1948, at 7:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy + Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature E. L. Royer M.D. Medical Examiner.
Date signed 5-2-48

VS 181

660851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

660851 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 138 N. Linwood Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Carrie E. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fe. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/12/82

8. AGE: Years 66yr. 65 | Months 4 | Days 20 20 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at Home

FATHER 12. Name Joseph Weber

13. Birthplace Md.

MOTHER 14. Maiden Name Isabel Dizner

15. Birthplace Balto. Md.

16 (a) Informant Mrs. Harry Myers (Sister)

(b) Address 138 N. Linwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/48 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 127 St. Paul St

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1948, at 11:45 M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6/48 19 , to 3/2/48 19 , and that I last saw her alive on 3/2/48 19

Immediate cause of death Cardiac failure

Due to Uterine - related cardiac - pulmonary disease

Due to

Other Conditions Uterine fibromyomatosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Coronary thrombosis, myocardium

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 3/2/48 at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature V. A. Stapleton M. D.

Address St Joseph's Hosp Date signed 3/4/48

660852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 ✓ Registered No. 660852

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St 16
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1019 N. Arlington Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country None

3 (a) FULL NAME Mary Elizabeth Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	Cd	Married

6 (b) Name of husband or wife William D. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 26 1899

8. AGE: Years	Months	Days	If less than one day
49		3	hr. min.

9. Birthplace Loudoun Co. Va.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Thomas King
13. Birthplace Va.

MOTHER
14. Maiden Name Martha J. Cook
15. Birthplace Va.

16 (a) Informant William D. Miller
(b) Address 1019 N. Arlington Ave

17 (a) Burial (b) Date thereof 3-5-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. City

18 (a) Funeral director Samuel W. Sullivan
(b) Address 1011 N. Arlington Ave.

19 MAR 4 1948 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/2 1948 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/11 1948 to 3/2 1948, and that I last saw h[illegible] alive on 3/2 1948.

Immediate cause of death	Duration
Pyelonephritis Cystitis	7
Vesicular Stasis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William Garner
Address 1514 Division St Date signed 3/4/48

VS 150

C60853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. C60853

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 51st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 64 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1824 N. Caroline St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Pietrowski

3 (b) If veteran, name war: WW 2

3 (c) Social Security Account No. 191-20-5869

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Shirley Sturms
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1918

8. AGE: Years	Months	Days	If less than one day
29	2	26	hr. min.

9. Birthplace Allentown, Pa.
(Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business

FATHER
12. Name Alexander Pietrowski
13. Birthplace Poland

MOTHER
14. Maiden Name Anna Costanovich
15. Birthplace Poland

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 8-48 (month) (day) (year)
(c) Cemetery or crematory U.S. National Cem
Location Grafton W. VA.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 (a) MAR 4 - 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1948, at 4 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 30 1947 to Mar. 3 1948, and that I last saw h. im alive on Mar. 3 1948.

Immediate cause of death	Duration
Lymphoma, diffuse in retroperitoneal lymph nodes, iliac nodes and	
Due to periaortic lymph nodes.	16 mos.
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence. at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. W. Taber, M.D.
Address US Marine Hosp. Date signed 3/3/48

VS 150

X

660854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

Registered No. 660854

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 6 days
(e) Length of stay in Baltimore (yrs., mos., or days): 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Ohio (b) County:
(c) City or town: Cincinnati,
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 547 Carlisle Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Harvey Sylvine Mursell

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
WW I	268-03-1924	M	col	Div.

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ? 1890

8. AGE: Years	Months	Days	If less than one day: hr.	min.
58				

9. Birthplace: Woodsford, Ky.
(Town, county, and state)
10. Usual Occupation: Night watchman
11. Industry or business:

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 4-48 (month) (day) (year)
(c) Cemetery or crematory: Mt Calvary
Location: Balto. Md.

18 (a) Funeral director: Ellsworth Armacost
(b) Address: 3911 Liberty Heights Ave.

19 (a) MAR 4 - 1948 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27 19 48 at 3:15A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 21 19 48 to Feb. 27 19 48, and that I last saw h im alive on Feb. 28 1948.

	Duration
Immediate cause of death: Carcinoma of esophagus with esophageal-bronchial fistula and bron-	Unknown
Due to: chial pneumonia	More than 1 wk.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed 3/2/48

VS 150

660855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 660855

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1144 Argyle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
Street No. 1144 Argyle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY B. MILLS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1877

8. AGE: Years	Months	Days	If less than one day
70	5	10 8	hr. 4 min.

9. Birthplace Davidsonville, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Jones
13. Birthplace Md.

MOTHER
14. Maiden Name Rosie Parker
15 Birthplace Md.

16 (a) Informant Miss Roberta Boston
(b) Address 1144 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St. Huntingdon Williams, Md.

19 (a) MAR 4 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH March 1, 1948, at 4:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1948, to Mar 1 1948, and that I last saw h[er] alive on Mar 1 1948.

Immediate cause of death	Duration
Cardio-Vascular-Renal Disease	7
Due to	
Due to	
Other Conditions Pulmonary Edema	2

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. F. Naylor

Address 6 r s N. Fremont Ave Date signed 3/5/48

V S 150

X

G60856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G60856

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1031 Mount St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 - 3
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1031 Mount St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Theressa Braxton ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Hezekiah Braxton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7 1897

8. AGE: Years	Months	Days	If less than one day
50	9		hr. min.

9. Birthplace Richmond Va. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Isaac Christian
13. Birthplace Richmond Va.

MOTHER
14. Maiden Name Maria Page
15. Birthplace Richmond Va.

16 (a) Informant Hezekiah Braxton
(b) Address 1031 Mount St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3/5/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A. Co. Md.

18 (a) Funeral director Metropolitan Fun. Homes
(b) Address 947 N. Mount St.

19 (a) MAR 4 - 1948 (Date rec'd by registrar) (b) Signature for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 2 1948, at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 27 1948, to Mar 2 1948, and that I last saw her alive on Mar 1 1948

Immediate cause of death	Duration
Lobar Pneumonia	4 days
Due to Cardio Vascular Renal Disease	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. William Frey, M.D.
Address 1928 Penna Ave Date signed 3/4/48

VS 150

X

G60857

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G60857

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Monument St
(c) Hospital or institution: Sinai 27
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 19
(d) Street No. Levindale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MRS YETTA ~~SOBOL~~ SOBOL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Meyer
13. Birthplace Russia

MOTHER
14. Maiden Name Fanye
15. Birthplace Russia

16 (a) Informant Louis Sobol
(b) Address 3713 Spaulding Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-4-48 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Mt Carmel

18 (c) Funeral director Jack Levy Inc
(b) Address 2106 Eutaw Place

19 (a) MAR 4 - 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1948, at 4 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-7 1948 to Mar. 3 1948 and that I last saw h[illegible] alive on March 3 1948

Immediate cause of death	Duration
Myocardial insufficiency and myocardial infarction	
Due to Arteriosclerosis and Hypertensive Cardio-Vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Allan J. Wolinsky M. D.
Address Sinai Hosp Date signed 3-3-48

VS 150

X

C60858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

102

Registered No. C60858

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton + Wilkens Ave
(c) Hospital or institution: St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3521 Gelston Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Norman B. Bussard

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Veronica E.

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Dec 28 1904

8. AGE: Years 43 | Months 2 | Days 4 | If less than one day hr. min.

9. Birthplace Maryland Balto. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business American Oil Co.

FATHER
12. Name Benjamin O. Bussard
13. Birthplace Md.

MOTHER
14. Maiden Name Ellen McCoy
15. Birthplace Md. Balto

16 (a) Informant Mrs. Veronica E. Bussard
(b) Address 3521 Gelston Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director John J. Cavanaugh Son
(b) Address 901-03 Hollins St.

19 MAR 4 - 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/3 1948, at 7:54 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1948 to March 3 1948, and that I last saw him alive on 2-2 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Malignant Hypertension	
Due to or As Hypertensive	
Other Conditions Encephalopathy -	

(Include pregnancy within 3 months of death)

Date of operation Feb 25, 1948

Major findings of operation: Left parabronchial squamous cell carcinoma

of autopsy: see above

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney J. Vanable Jr. M.D.
Address St Agnes Hospital Date signed 3-4-48

VS 130

G60859 WILCHINSKI G60859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp. 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 130 S. Eden St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Wilchinski

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Adolph J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/6/1896

8. AGE: Years	Months	Days	If less than one day
52	?	2	hr. min.

9. Birthplace Europe (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At home

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant husband Adolph J.
(b) Address 130 S Eden St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Belair Rd

18 (a) Funeral director Joseph Kasenskas Inc
(b) Address 67 Washington Blvd

19 (a) MAR 4 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 3 1948, at 2:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 2 1948 to Mar 3 1948, and that I last saw her alive on Mar 3 1948.

Immediate cause of death Respiratory failure — Duration 72 hrs

Due to Pneumonia — 3 wks

Due to — over

Other Conditions Tuberculosis inactive
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence , at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Vincent D. Fitzpatrick M.D.
Address St. Joseph's Hosp. Date signed 3/8/48

VS 150

Vincent D. Fitzpatrick M.D.

660860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registered No. 660860

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7205 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Fine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Albert Fine
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 4/7/1906

8. AGE: Years	Months	Days	If less than one day
41 years	10	26	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Samuel Sappersstein
13. Birthplace Russia

MOTHER
14. Maiden Name ? Jennie
15. Birthplace Russia

16 (a) Informant Mr Albert Fine
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 5/48 (month) (day) (year)
(c) Cemetery or crematory Bath Hebrew Cemetery
Location Windsor Mill Road
18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W North ave
19 (a) (Date received by Local Registrar) (b) Certified by Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/3 1948, at 3 M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-31 1947 to 3/3 1948 and that I last saw her alive on 3/3 1948

Immediate cause of death	Duration
Leukaemia, Chronic	
Due to myeloid	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman E. Shamer M. D.
Address Johns Hopkins Hospital Date signed 3-3-48

VS 150

G60861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G60861

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 413 Normandy Ave D.S.A.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 413 Normandy Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis C. Suite (Lewis Tuitt)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Daisy B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1891

8. AGE: Years	Months	Days	If less than one day
56	9	24	hr. min.

9. Birthplace Rhode Island
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Thomas Suite
13. Birthplace England

MOTHER
14. Maiden Name
15. Birthplace England

16 (a) Informant Mrs. Daisy Suite
(b) Address 413 Normandy Ave.

17 (a) Burial (b) Date thereof 3 / 6 / 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory National Cem.
Location Baltimore, Md.

18 (a) Funeral director Harry A. Wiltse
(b) Address 4101 Edmondson Ave

19 (a) MAR 4 - 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/2 1948, at 2 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Faberelli M.D.
Medical Examiner.
Date signed 3/2/48

VS 131

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G60862

G60862

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 104 N. FULTON AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 48yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 104 N. FULTON AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CATHERINE HANSELY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOWED

6 (b) Name of husband or wife late JOHN HANSELY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1879

8. AGE: Years	Months	Days	If less than one day
68	2	12	hr. min.

9. Birthplace AUSTRIA (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name STEVEN GOWBITS
13. Birthplace AUSTRIA

MOTHER
14. Maiden Name MARIA KVASNAK
15. Birthplace AUSTRIA

16 (a) Informant Mr CHARLES HANSELY
(b) Address 266 N. ~~Fulton Ave~~ Milton St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MARCH 6 '48 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location OLD FREDERICK RD

18 (a) Funeral director Harry A Wyle
(b) Address 4106 Edmondson Ave

19 (a) MAR 4 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 2 1948, at 6:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1948 to March 2 1948 and that I last saw her alive on March 1 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Carcinoma large bowel	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. Alexofski M.D.
Address 601 N. Monroe St Date signed 3/4/48 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G60863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45 F

Registered No. G60863

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3112 Hudson St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3112 Hudson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) 5
If yes, name country

3 (a) FULL NAME Martin Mullaney

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-05-4273

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ida Mullaney
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Oct 30, 1889

8. AGE: Years	Months	Days	If less than one day
58	4	2	____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Chamber of Commerce

FATHER
12. Name Elizabeth Bock
13. Birthplace Cumberland, Md

MOTHER
14. Maiden Name Thomas P. Mullaney
15. Birthplace Baltimore, Md.

16 (a) Informant Ida Mullaney
(b) Address 3112 Hudson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-48 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Randall Ave.

18 (a) Funeral director Robert F. Leathersich Jr.
(b) Address 1040 S. Kenwood Ave.

19 (a) MAR 4 1948 (Date rec'd by registrar) (b) Washington Wilkinson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1948 at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-15 1947 to Mar 2 1948 and that I last saw h(im) alive on Mar 2 1948

Immediate cause of death	Duration
Squamous Cell Carcinoma of Neck	1 yr.
Due to Partly Hard-palate Pharynged origin	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Joseph Tarbay M.D.
Address 441 E. Ellwood Ave Date signed 3/5/48

VS 150

X

660864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

660864 Registered No.

GM. 116388

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) 23 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 917 Arlington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jane Hall (Lambson)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27- 1907

8. AGE: Years	Months	Days	If less than one day
40	10	5	hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Rudolph Hall
13. Birthplace MD.

MOTHER
14. Maiden Name Emma (D)
15. Birthplace MD.

16. (a) Informant Records Balto. City Hospital
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. A. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) MAR 1948 (b) Registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-2- 1948, at 12.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 - 25 - 1948 to 3 - 2 - 1948, and that I last saw her alive on 3 - 2 - 1948

Immediate cause of death: Azotemia — Duration

Due to: Malignant Hypertension

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 2-28-48

Major findings of operation Structure 2 Metastasis to Lymphopathia Venerea

of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm R Hamburger M. D.

Address Balto City Hosp. Date signed 3-5-48

VS 150

C60865JL - 90374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH, 12B

C60865 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1430 N. Mount St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia Bens

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: C
6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16. 1[illegible]

8. AGE: Years 69 | Months 6 | Days 17 | If less than one day: hr. min.

9. Birthplace Ga. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Berry Bell
13. Birthplace Ga.

MOTHER
14. Maiden Name Louise ?
15. Birthplace Ga.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location md.

18 (a) Funeral director Leo. H. Olson
(b) Address 1303 Pressman St

19 (a) MAR 4 - 1948 (Date rec'd by registrar) Huntington Williams, M.D.

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1948, at 12.45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 24, 1944 to Mar. 2 1948, and that I last saw her alive on March 2 1948.

Immediate cause of death Bilateral Far advanced Pulmonary Tuberculosis with cavitation — Duration 4 yrs. ?

Due to Fibrinous Pericarditis and

Due to Osc'ds due to above

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr M. D.
Address Baltimore City Hosp Date signed 3-4-48

660866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44B

Registered No. 660866

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Green & Ironland St
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days): 30
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County: Dorchester
(c) City or town: Cambridge, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 207 Henry St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Mrs. Melvin Gatton (Mrs. Melvin Gatton)

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 22, 1922

8. AGE: Years: 25 | Months: 9 | Days: 11 | If less than one day: hr. min.

9. Birthplace: Cambridge, Md.
(Town, county, and state)

10. Usual Occupation:

11. Industry or business:

FATHER
12. Name:
13. Birthplace:

MOTHER
14. Maiden Name:
15. Birthplace:

16 (a) Informant:
(b) Address:

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mch 6/48 (month) (day) (year)
(c) Cemetery or crematory: Dorchester Memorial Park
Location: Cambridge, Md

18 (a) Funeral director: Johns & Whitelock Home
(b) Address: 1900 Gautier Place

19 (Date rec'd by local registrar) MAR 4 1948 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-3 1948, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1 1948 to 3-3 1948, and that I last saw him alive on 3-3 1948.

Immediate cause of death: Cardiac failure — Duration:

Due to: Bodyline Disease

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Howard E. Hull

Address: Univ. Hosp. Date signed: 3-3-48 M. D.

G60867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G60867 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1933 Fleet St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Corson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Edna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-25-85

8. AGE: Years 63 | Months 0 | Days 9 | If less than one day hr. min.

9. Birthplace Calif (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Harry Corson

13. Birthplace ? Calif

MOTHER 14. Maiden Name Mary

15. Birthplace Calif

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/48 (month) (day) (year)

(c) Cemetery or crematory Arlington Nat. Cem.

Location Arlington Va.

18 (a) Funeral director W. W. Chambers Co.

(b) Address Washington D. C.

19 (a) 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-3-48, at 11:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-21 1948 to 3-3-48 1948, and that I last saw h alive on 3-3 1948.

Immediate cause of death: Pulmonary tuberculosis — Duration: 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Peter A. McKusick M. D.

Address [illegible] Date signed 3/11/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G60868

BALTIMORE CITY HEALTH DEPARTMENT ✓ G60868 Registered No.

CERTIFICATE OF DEATH 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 136 W. Camden St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 2 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 136 W. Camden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Irvin J. Delker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ella M. Delker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1901

8. AGE: Years 46 | Months 4 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Charles M. Delker
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Easter
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Ella M. Delker
(b) Address 136 W. Camden St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 5, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

MAR 4 - 1948 (b) Date rec'd by registrar Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1948 at 7.30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1, 1946 to Feb 24 1948. and that I last saw h[illegible] alive on Feb 24 1948.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 3 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Schuffel M. D.
Address 136 W. Camden St. Date signed 3/4/48

VS 150

X

C60869 ✓ C60869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D. of H
(b) Street address
(c) Hospital or institution West Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2737 Baker St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert F. Bokman ✓

3 (b) If veteran, name war W.W I
3 (c) Social Security Account No. 277-14-8287

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Rietta Bokman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1894

8. AGE: Years 54 | Months 1 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name August Bokman
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Carrie Rayfield
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Mamie R. Hemsley
(b) Address 2737 Baker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave

19 (a) 3089 (Registered by Registrar) (b) Washington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/2 1948, at 3 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to
Inhaling gas.
Due to
Other Conditions Despondency
(Include pregnancy within 3 months of death)

If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/2/48 at about 1 P M.
(b) Where did injury occur? 2737 Baker St
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Gas inhalation from ½ burner of stove at home

23. Signature [illegible] M.D. Medical Examiner.
Date signed 3/3/48

VS 181

G60870 BALTIMORE CITY HEALTH DEPARTMENT G60870
CERTIFICATE OF DEATH 937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 421 So Chester st
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 31 (If outside city or town limits, write RURAL and give town)
(d) Street No. 421 So Chester st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME VICTORIA RADZIEWICZ OR ROGERS

3 (b) If veteran, name war | 3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband ~~or wife~~ Michael (Deceased)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec-23-1876

8. AGE: Years 71 | Months 2 | Days 11 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Anthony Bolasz
13. Birthplace Poland

MOTHER
14. Maiden Name Maryanna ?
15. Birthplace Poland

16 (a) Informant John Rogers (Son)
(b) Address 345 N Kenwood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-48 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore Md

18 (a) Funeral director George A Weber
(b) Address 705 So Ann st

19 (a) (Date received by registrar) (b) Registered No.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3rd 1948, at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 27 1948, to Mar 3 1948, and that I last saw her alive on Mar 1 1948.

Immediate cause of death: Arterio-sclerosis-severe Hypertensive Heart Disease — Duration: yrs. / yrs. ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lenga D. Lipsey M. D.
Address 1 W Pratt St Date signed 3/4/48

V S 150

660871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 660871

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 516 E Eager St
(c) Hospital or institution:
10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 E. Eager St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose McNulty

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: James J. McNulty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1871

8. AGE: Years 76 | Months 3 | Days 25 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business at Home

FATHER
12. Name James O'Neill
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Reilly
15. Birthplace Ireland

16 (a) Informant Mrs. James J. McNulty Jr.
(b) Address 516 E. Eager St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 5, 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location 4300 Old Frederick Rd

18 (a) Funeral director Elmer W. Cookerson
(b) Address 924 E. Eager St.

19 (a) MAR 4 1948 (b) Huntington Williams, M.D. Registrar
(Accepted by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 1 1948, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 25 Feb 1948 to 1 Mar 1948 and that I last saw her alive on 1 Mar 1948.

	Duration
Immediate cause of death: myocardial failure	6 days
congestive failure	
Due to: Cardio-Vascular-Renal disease	?
Due to:	
Other Conditions: arthritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Silverfer M.D.
Address 714 E. Preston Date signed 3 Mar 48

V S 150

G60872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G60872

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address MERCY HOSPT

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 624 E EAGER ST.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME WALTER VINCENT WILSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife BERTHA SHEPPS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace BALTO., MD

(Town, county, and state)

10. Usual Occupation CLERK

11. Industry or business RAILWAY EXPRESS.

FATHER

12. Name GEO. WILSON

13. Birthplace IRELAND

MOTHER

14. Maiden Name MARY NORTON

15. Birthplace IRELAND

16 (a) Informant MRS. WALTER V. WILSON

(b) Address 624 E. EAGER ST

17 (a) Burial (b) Date thereof 3-6-48

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory CATHEDRAL CEM.

Location BALTO., MD.

18 (a) Funeral director WIEDEFELD & SON

(b) Address GREENMOUNT & 22ND ST.

19 Filed MAR 4 1948 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-4 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948 19 to Mar 3 1948 and that I last saw him alive on Feb 25 1948

Immediate cause of death: Arteriosclerotic HH Disease — Duration: 3 yrs

Due to

Due to

Other Conditions Cystic Fibrillat.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Sol Smith

Address 1223 E NORTH Date signed 3/4/48

VS 150

660873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No. 660873

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun Fayette Sts.
(c) Hospital or institution: Franklin Square Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1136 S. Charles St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Ella Fitzhugh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles Fitzhugh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 20, 1895

8. AGE: Years	Months	Days	If less than one day
52	5	15	hr. min.

9. Birthplace Cambridge, Md. (Town, county, and state)
10. Usual Occupation N. W.
11. Industry or business

MOTHER | FATHER
12. Name Walter Twimby
13. Birthplace Maryland.
14. Maiden Name Juanita Roark
15. Birthplace Maryland.

16 (a) Informant Charles Fitzhugh
(b) Address 1136 S. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem
Location Glen Burnie Md

18 (a) Funeral director Bernard C Hanke
(b) Address 131 E West St

19 (a) MAR 4 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4th 1948, at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1st 1948 to March 4th 1948 and that I last saw her alive on March 4th 1948.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Intestinal obstruction, chronic	
Due to Cause unknown	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Fred Hawkins Jr M. D.
Address Franklin Square Hosp. Date signed 3/4/48

VS 150

660874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

660874 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address South Balto. Gen. Hosp.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Riverside Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Michael J. Mc Neal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret C. McNeal
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 8-1891

8. AGE: Years	Months	Days	If less than one day
56	4	26	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation ?
11. Industry or business Laborer

FATHER
12. Name Edward F. Mc Neal
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary Carr
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Margaret C. McNeal
(b) Address 1208 Riverside Ave

17 (a) Burial (b) Date thereof 3-6-1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location A. A. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1476 Light St.

19 MAR 4 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1948, at 8 30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-8 1945, to 3-3- 1948 and that I last saw h[illegible] alive on 2-28 1948.

Immediate cause of death	Duration
Chronic Myocardial Degeneration	3 yr.
Due to Rheumatic Fever	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Tallod M. D.
Address 707 E. Fort Ave. Date signed 3-3-48

VS 150

X

660875 Approved by State Board of Examiners 186a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660875

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Relay (If outside city or town limits, write RURAL and give town)
(d) Street No. Relay Sanatorium (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Prudencio Paul Scharf

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Washington, D.C. (Town, county and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Samuel Royston Scharf
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Fannie Young
15. Birthplace Balto, Md.

16 (a) Informant
(b) Address

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 3/4/48 (month) (day) (year)
(c) Cemetery or crematory
Location Wash. D.C.

18 (a) Funeral director JOSEPH GAWLER & SONS
(b) Address Washington, D.C.

19 (a) MAR 4 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 3 1948 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-25 1948 to 3-3 1948 and that I last saw h. alive on 3-3 1948

Immediate cause of death Cardiac failure

Due to Toxicity due to Terramycin Broncho-

Due to pneumonia, secondary to post. nasal

Other Conditions ost tumor.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Feb 25 at ? M
(c) Where did injury occur? Relay (City or town) Balto (County) Md (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Sanatorium (Specify type of place) While at work?
(e) Means of injury Dropped, fell to floor

23. Signature C. G. Hearne C. G. HEARNE, M. D.
Address Univ. Hosp. Date signed 3-3-48

Approved by C.P. Fahrney M.D. 3/3/48 Medical Investigator

VS 150

G60876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G60876

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 712 ALLENDALE 57

(c) Hospital or institution: 16-8

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)

(d) Street No. 712 ALLENDALE ST.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILHELMINA G. HORN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	WIDOW

6 (b) Name of husband or wife GEO. C. HORN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 3, 1887

8. AGE: Years	Months	Days	If less than one day
60	3	29	hr. min.

9. Birthplace BALTIMORE
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name FREDERICK DIETZ

13. Birthplace GERMANY

MOTHER 14. Maiden Name MARIA ZIMMERMAN

15. Birthplace GERMANY

16 (a) Informant Mr. Herman M. Hipsley

(b) Address 327 S. Macon St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/48 (month) (day) (year)

(c) Cemetery or crematory ST. PAUL

Location VIOLETSVILLE MD.

18 (a) Funeral director WM. J. TICKNER & SON

(b) Address BALTIMORE MD.

19 MAR 4 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/2/48 19..., at 8.10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1, 1947 to March 2 1948 and that I last saw h.er alive on March 2, 1948

Immediate cause of death	Duration
Chronic Myocarditis	2 Yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature [signature]

Address 2757 W. Mont Date signed 3/2/48 M. D.

VS 150

G60877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No. G60877

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St & Rutland Ave.

(c) Hospital or institution: Sinai Hospital 27-20

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 7301 Park Heights Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LORENA B. JOHNSON

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: NO

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: DIVORCED

6 (b) Name of husband or wife: CLARENCE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): NOV. 17, 1898

8. AGE: Years 49 | Months 3 | Days 16 | If less than one day ... hr. ... min.

9. Birthplace: LOS ANGELES CAL.
(Town, county, and state)

10. Usual Occupation: HOUSEWIFE

11. Industry or business: —

FATHER

12. Name: C. W. APPLERY

13. Birthplace: UNK

MOTHER

14. Maiden Name: "

15. Birthplace: "

16 (a) Informant: HOSP. RECORDS

(b) Address

17 (a) CREMATION (Burial, cremation, or removal) (b) Date thereof 3/5/48 (month) (day) (year)

(c) Cemetery or crematory: GREENMOUNT CRM.

Location: BALTIMORE MD

18 (a) Funeral director: WM. J. TICKNER & SONS

(b) Address: BALTIMORE MD

19 (a) MAR 4 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1948, at 5:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 21 1948 to Mar. 3, 1948 and that I last saw her alive on Mar. 3, 1948

Immediate cause of death: Intestinal obstruction — Duration

Due to: Adhesions

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature: Wm. M. Tickner

Address: Sinai Hospital Date signed 3-4-48 M.D.

VS 150

X

660878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 660878

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 27 N Carey St 28-4

(c) Hospital or institution: Good Samaritan Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 wk

(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 7 S. Woodington Rd. (If rural give location)

(e) Citizen of foreign country? — (Yes or No) If yes, name country

3 (a) FULL NAME JESSE DANIEL RINE

3 (b) If veteran, name war: NONE

3 (c) Social Security Account No. NONE

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: WIDOWER

6 (b) Name of husband or wife: CORA REBECCA RINE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 18, 1865

8. AGE: Years 82 Months 3 Days 6 16 If less than one day hr. min.

9. Birthplace FREDERICK, MD. (Town, county, and state)

10. Usual Occupation GROCER - (RETIRED-10 YRS)

11. Industry or business SELF

FATHER 12. Name JOHN W. RINE

13. Birthplace FREDERICK, MD.

MOTHER 14. Maiden Name CATHERINE LEASE

15. Birthplace FREDERICK, MD.

16 (a) Informant MR. T. MILLARD RINE

(b) Address 7 S. WOODINGTON RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/6/48 (month) (day) (year)

(c) Cemetery or crematory WESTERN CEM Location BALTIMORE, MD.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address BALTIMORE, MD.

19 MAR 4 - 1948 (Date rec'd by registrar) (b) Huntington Wm. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4th 1948, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 3 1948, to March 3 1948, and that I last saw h— alive on March 3 1948.

Immediate cause of death	Duration
Acute Cardiac Dilatation	Coma Long
Due to Cardio Vascular disease	2
Due to	
Other Conditions Uremia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Harry Glassman M. D.

Address 26 N Washington Ave Date signed March 5 48

V S 150

G60879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 111B

Registered No. G60879

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2336 Druid Park Drive
(c) Hospital or institution:
15-12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2336 Druid Park Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude A. Bortner

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~: Daniel G. Bortner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 10th 1889

8. AGE: Years: 58 | Months: 10 | Days: 7 2/3 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: Charles L. Vogelman
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Annie T. Rogan
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mr. Daniel G. Bortner
(b) Address: 2536 Druid Park Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: March 6th 1948 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Md.

18 (a) Funeral director: Wm. J. Tickner & Sons.
(b) Address: North & Pennsylvania Aves.

19 MAR 4 - 1948 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3 1948, at 5:00 P.M.

21. I certify that I took charge of the remains described above, held an Ext & Insp thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Acute pulmonary Edema

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: William G. Kilpatrick M.D. Medical Examiner
Date signed 3/4/48

VS 151

660830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registration No. 660830

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3605 Hilldale Ave.
(c) Hospital or institution: Anderson's Nursing Home 28-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2912 OAKHILL Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elizabeth ELIZABETH HALL KENT

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUN 17, 1871

8. AGE: Years	Months	Days	If less than one day
76	8	16	hr. min.

9. Birthplace CAMDEN N.J.
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name JESSE HALL
13. Birthplace CAMDEN, N.J.

MOTHER
14. Maiden Name SARAH CAVANAUGH
15. Birthplace CAMDEN N.J.

16 (a) Informant MR. J. HALL KENT
(b) Address 2912 OAKHILL AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PK
Location BALTIMORE, MD

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address BALTIMORE, MD.

19 (a) MAR 4 - 1948 (Date rec'd by registrar) (b) Huntington Pennsylvania

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1948, at 5 40 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1948 to March 2 1948, and that I last saw h ey alive on March 2 1948.

	Duration
Immediate cause of death: Congestive Heart Failure	4 days
Due to: Arteriosclerotic cardio-vascular renal disease	8 years
Due to:	
Other Conditions: Hypertensive cardio vascular disease	6 years

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: None made

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Millard T. Eveland Jr. M.D.
Address 3400 Woodbine Ave. 7 Date signed Mar 3 1948

VS 150

660881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. 660881

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 12
(b) Street address 33rd & Calvert St.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore 18 Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2221 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ALICE CARDELIA KLAIR

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Mr. Hiram A. Klair
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) October 24, 1880

8. AGE: Years	Months	Days	If less than one day
67	4	9/10	hr. min.

9. Birthplace BALTIMORE (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business House wife

FATHER
12. Name Leroy Steiner
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Douglas
15. Birthplace Virginia

16 (a) Informant Son - ALBERT KLAIR
(b) Address 2017 E. BELVEDERE AVE

17 (a) Burial (b) Date thereof 3/6/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON PK
Location BALTIMORE, MD

18 (a) Funeral director WM. T. TICKNER & SONS
(b) Address BALTO. MD.

19 (a) MAR 4 1948 (b) Huntington Williams, M.D.
(Filed by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-3-48 1948, at 10:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 19 , to Mar. 3 1948.
and that I last saw h e v alive on Mar. 3 1948.

Immediate cause of death Cong. Failure — Duration 15 min.
Heart Failure

Due to Coronary Heart Failure — 7 days
Arteriosclerotic Heart Disease — ?

Due to Perforated gastric Ulcer
Cir. or Perforated Diverticulitis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John R. Smith, Jr., M.D.
M. D.
Address Date signed

VS 150

X

G60882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G60882
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Druid Hill Ave.
(c) Hospital or institution: D.O.A. University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar TUCKER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1905

8. AGE: Years 43 | Months 1 | Days 21 | If less than one day hr. min.

9. Birthplace Calvert Co. Md.
(Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER
12. Name unknown
13. Birthplace ?

MOTHER
14. Maiden Name unknown
15. Birthplace ?

16 (a) Informant George A. Johnson
(b) Address 324 W. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary.
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

MAR 4 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24 1948, at 2:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Myocardial degeneration
Acute pulmonary edema
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 2/25/48

VS 151

G60883 ✓ G60883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2515 W. Baltimore St.
(c) Hospital or institution: 20-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2515 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Emma Lisbeth Desor

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles Jacob Desor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1865

8. AGE: Years 82 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Two Taverns, Pennsylvania
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name David Wherley
13. Birthplace Pa.

MOTHER
14. Maiden Name Margaret Garrick
15. Birthplace Pa.

16 (a) Informant Charles A. Desor
(b) Address 39 N. Monastery Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Maryland

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave.

19 (a) MAR 4 1948 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1948, at 6:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17 1940 to March 3, 1948 and that I last saw her alive on March 3, 1948.

	Duration
Immediate cause of death: Cerebral hemorrhage	1 Day
Due to: Hypertension	7½ years
Due to: Arteriosclerosis, generalized	7½ years
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gilbert L. Rudman M. D.
Address 2517 W. Baltimore St. Date signed March 4, 1948

VS 150

Washington Hollidaysburg, Pa

X

G60884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G60884 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 106 S. Fulton Ave.
(c) Hospital or institution: — 19-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 S. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Clarence Grainer Handy

3 (b) If veteran, name war	3 (c) Social Security Account No.
0	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	widowed.

6 (b) Name of husband or wife Rhoda
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8 1876

8. AGE: Years	Months	Days	If less than one day
71	11	26	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Painting

FATHER
12. Name Charles Handy
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Rachel Matthews
15. Birthplace Elkton Md.

16 (a) Informant Clarence B. Handy
(b) Address 261 Chesapeake Bx 548 Rock *

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 3-4-48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilbur Coombs
(b) Address 1217 Eutaw St

19 (a) MAR 5 1948 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1948, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945 to March 4 1948, and that I last saw him alive on March 3 1948.

Immediate cause of death	Duration
Myocardial Failure	1 week
Due to Arteriosclerotic Myocarditis	1 year
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation	
of autopsy: none	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Morris B. Schreeder M. D.
Address 548 S. Fulton Ave. Date signed 3-4-48

X

Spangenberg

BALTIMORE CITY HEALTH DEPARTMENT

G60885

Registered No. G60885

BC - 48-0473 CERTIFICATE OF DEATH 1579

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St Agnes Hospital 7N-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 404 S. Pulaski St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Spangenberg SPANGENBERG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/3/48

8. AGE: Years | Months | Days | If less than one day hr. 25 min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Ruth A. Spangenberg
15. Birthplace Baltimore Md

16 (a) Informant Ruth A. Spangenberg
(b) Address 404 S. Pulaski St

17 (a) Burial **(b) Date thereof** March 5-948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director Sott & B. M. Walton
(b) Address Pratt Street

MAR 5 1948
(Date rec'd by registrar) (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/3 1948 at 6:46 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/3 1948 to 3/3 1948 and that I last saw h[illegible] alive on 3/3 1948.

Immediate cause of death Unknown

Due to —

Due to —

Other Conditions 100 % phalocele

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

Autopsy: permit denied

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. N. D'Elia Sr.
Address St. Agnes Hosp **Date signed** 3/4/48

VS 150

660886 HEALTH DEPARTMENT—CITY OF BALTIMORE 660886

CERTIFICATE OF DEATH

131a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 N Pulaski St. Ward) 18-1

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... da. How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

2. FULL NAME Walter Hicks

If U.S. Veteran specify WAR ...

(a) Residence: No. 411 N Pulaski St. Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. Color or Race Col

5. Single, Married, Widowed, or Divorced (write the word) Single

6a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, year) Oct 4, 1883

7. AGE Years 65 (3) Months — 4 Days — 29 If LESS than 1 day, ... hrs. or ... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Labour

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —

10. Date deceased last worked at this occupation (month and year) ...

11. Total time (years) spent in this occupation ...

12. BIRTHPLACE (city or town) (State or country) Virginia

FATHER

13. NAME William Hicks

14. BIRTHPLACE (city or town) (State or country) Fayetteville Va

MOTHER

15. MAIDEN NAME Maria Hughes

16. BIRTHPLACE (city or town) (State or country) Fayetteville Va.

17. INFORMANT Alonzo Hicks

(Address) 537 N. Gilmore St

18. BURIAL, CREMATION, OR REMOVAL

Place Mt. Calvary Cem. Date March 8 1948

19. UNDERTAKER Mr. Gift A. Elliott Dept.

(Address) 1297 N. Caroline St.

20. MAR 5 - 1948 ... 19.. Registrar for Williamsburg, Va.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Mar. 3, 1948

22. I HEREBY CERTIFY, That I attended deceased from Feb 17 1948 to Mar 3 1948

I last saw him alive on Mar 3 1948 Death occurred on the date stated above, at 10:30 a.m. p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Nephritis	
Other contributory causes of importance:	

Was an operation performed? No Date of —

For what disease or injury? —

What test confirmed diagnosis? ... Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ... 19..

Where did injury occur? ... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify ...

(Signed) Dawn E. Wagner M.D.

(Address) 2027 Calvert St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

660887

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 937

Registered No. 660887

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3116 Fait Avenue
(c) Hospital or institution: 1-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3116 Fait Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM EDWARD SWAYNE

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 212-12-9813

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Sarah Elizabeth
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) July 18, 1869

8. AGE: Years	Months	Days	If less than one day
78	7	16 14	hr. min.

9. Birthplace Baltimore County
(Town, county, and state)
10. Usual Occupation
11. Industry or business Turners Warehouse

FATHER
12. Name John Swayne
13. Birthplace Maryland

MOTHER
14. Maiden Name Sophia Myers
15 Birthplace Maryland

16 (a) Informant Mrs. Sarah E. Swayne
(b) Address 3116 Fait Avenue -24

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/48 (month) (day) (year)
(c) Cemetery or crematory Cokesburg Memorial Cem.
Location Abington, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) MAR 5 1948 (Date received by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1948, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1 1947, to 3-3 1948, and that I last saw him alive on 3-2- 1948.

Immediate cause of death	Duration
Chr. Myocarditis	?
Due to Hypertrophied prostate	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. J. Davidow M. D.
Address 3218 Eastern Date signed 3-4-48

VS 150

660888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 660888

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3201 Barkley St.

(c) Hospital or institution: 12-7

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3201 Barkley St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah C. Keys

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Roy Keys
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1897

8. AGE: Years 51 | Months 50 | Days 1 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

MOTHER / FATHER

12. Name Dennis Spriggs

13. Birthplace Maryland

14. Maiden Name Mary Solyssa

15. Birthplace Maryland

16 (a) Informant Dennis Spriggs

(b) Address 3201 Barkley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/48 (month) (day) (year)

(c) Cemetery or crematory

Location White Hall, Md.

18 (a) Funeral director A. Delahay Halstead

(b) Address 918 Wilmot Hill Ave.

19 (a) MAR 5 - 1948 (Date rec'd by registrar) (b) Registrar

Arlington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-4 1948 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 1, 1948 to Mar. 4, 1948, and that I last saw her alive on Mar. 3, 1948.

Immediate cause of death: Diabetic Coma — Duration 24 hrs.

Due to Diabetes Mellitis — unknown

Due to

Other Conditions Arteriosclerosis — unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Geo. W. Murgatroyd M.D.

Address 401 E. 25th. St. Date signed 3/4/48.

VS 150

Geo. W. Murgatroyd

660889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

660889 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 930 Mason St.
(c) Hospital or institution: 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 930 Mason St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore McDonald Gibson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Ethel M

6 (b) Name of husband or wife

6 (c) If alive, give age 89 90 years

7. Birth date of deceased (mo., day, yr.) July 25 (1872)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
56	7	10		

9. Birthplace Md.
(Town, county and state)

10. Usual Occupation Decorator

11. Industry or business

FATHER 12. Name Isaac Gibson

13. Birthplace Westminster

MOTHER 14. Maiden Name Josephine ?

15. Birthplace Md.

16 (a) Informant Ethel Gibson

(b) Address 930 Mason St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-48 (month) (day) (year)

(c) Cemetery or crematory National Cemetery
Location Baltimore

18 (a) Funeral director A. Holstead Neal

(b) Address 918 Edmondson Ave

19 (a) MAR 5 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1948, at 10 1/2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1948 to March 4 1948 and that I last saw h[illegible] alive on March 4 1948.

Immediate cause of death Myocardial Failure — Duration:)

Due to Generalized Arterio-Sclerosis

Due to

Other Conditions Hemiplegia Lft.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gilbert L. Banfield M. D.

Address 722 N. Fulton Ave Date signed 3-4-48

VS 180

97

C60890 Hayward
115 E. Eager St.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH V133a

Registered No. C60890

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4603 Crosswood Road
(c) Hospital or institution: 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4603 Crosswood Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E. MEYER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife George P. Meyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20, 1869

8. AGE: Years	Months	Days	If less than one day
78	3	11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Raymond Hoffmeister
(b) Address 4603 Crosswood Road

17 (a) Burial (b) Date thereof 3/5/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, #14.

19 (a) MAR 5 - 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2nd 1948, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1938 to Mar 2 1948, and that I last saw h. Or alive on Mar 2 1948.

Immediate cause of death	Duration
Hypostatic Pneumonia	3 days
Due to Cystitis + pyelitis	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. N. Hayward
Address 115 E Eager St Date signed 3-4-48 M. D.

VS 150

G60891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G60891

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18 2
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1103 West Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter QUEEN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 55 (45) | Months | Days | If less than one day ... hr. ... min.

9. Birthplace a. a. co. md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Thomas Queen

13. Birthplace md

MOTHER 14. Maiden Name Catterine —

15. Birthplace md

16 (a) Informant Lester Snowden

(b) Address Glenburnie, md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director James Adams

(b) Address 142 Wadsil St

19 (a) MAR 5 1948 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1948 at 9 A.M 45

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed 3/2/48

C60892

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. C60892

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20-6
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore City.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 31 N. Ellamont St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ida B. Shull

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Alexander B. Shull deceased
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1859

8. AGE: Years	Months	Days	If less than one day
89	0	20	hr. min.

9. Birthplace Mansfield, Ohio
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Richard White
(b) Address 31 N. Ellamont St. Balto

17 (a) Burial (b) Date thereof 3-6-48
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Morgan Chapel
Location Woodfine Carroll Co. Md

18 (a) Funeral director E. M. Walz
(b) Address Westfield, Md.
Huntington or Williamsport, Md.

19 (MAR 5 1948) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-4 1948, at 4 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-2 1948 to 3-4 1948, and that I last saw her alive on 3-4 1948.

Immediate cause of death Coronary Occlusion — Duration

Due to

Due to

Other Conditions Thrombosis left femoral artery
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: an absence

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph L. Zuma M. D.
Address Sinai Hospital Date signed 3-5-48

VS 150

660893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

660893 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave.
(c) Hospital or institution: Maryland General Hospital 28-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4402 Maine Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Malcolm Wright

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-9320

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Kate E. Wright

6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) June 14, 1870

8. AGE: Years 77 ~~78~~ | Months 8 | Days 20 | If less than one day hr. min.

9. Birthplace Canada
(Town, county, and state)

10. Usual Occupation Electrical Engineer

11. Industry or business Baltimore Transit Co.

FATHER
12. Name Damon Wright
13. Birthplace Canada

MOTHER
14. Maiden Name Jane Rumble
15. Birthplace Canada

16 (a) Informant Mrs. Kate E. Wright
(b) Address 4402 Maine Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 6, 1948 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Miller & Leimroth
(b) Address 4548 Liberty Heights Ave.

19 (a) MAR 5 1948 (Date rec'd by registrar) (b) Registrar Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1948, at 8 25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/24 1948 to 3/4 1948, and that I last saw him alive on 3/4 1948.

Immediate cause of death Uremia — Duration 2 days

Due to Cerebro-vascular accident — 9 days

Due to Hypertensive Cardiovascular-Renal Disease — 5 years

Other Conditions Diabetes Mellitus — ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cerebral ventricular hemorrhage

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alfred N. Dann M. D.
Address Maryland General Hosp. Date signed 3/4/48

VS 150

131a

A serious matter if wrong, with penalties attaching. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

660894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. 660894

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1-5
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 E. Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Clarence Taylor

6 (c) If alive, give age 3 years

7. Birth date of deceased (mo., day, yr.) 1944

8. AGE: Years	Months	Days	If less than one day
3 4 MT.			hr. min.

9. Birthplace Camden S. C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Daniel Adamson
13. Birthplace Camden S. C.

MOTHER
14. Maiden Name Frances Warren
15. Birthplace Camden S. C.

16 (a) Informant Ethel Revis
(b) Address 1930 E. Chase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-9-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Elroy S. Wilson
(b) Address 1000 Bdantley ave

Filed MAR 5 - 1948 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1948 at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of Head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-3-48 at 1:03 P.M.
(b) Where did injury occur? 1516 E. Monument St.
(c) Did injury occur at home, on farm, industrial place, in public place? home, While at work? no
(d) Means of injury Gun Shot Wound

23. Signature Earl K. Long M.D. Medical Examiner.
Date signed 3-4-48

VS 151

660895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 660895

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 255

(a) Baltimore City, Maryland

(b) Street address 4703 Pennington Ave

(c) Hospital or institution: St Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 da

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4703 Pennington Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Roland Garnett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Alive

Bertha Spindle 6 (c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr) May 16 1875

8. AGE: Years	Months	Days	If less than one day
73 (74)	9	17	hr. min.

9. Birthplace Virginia (Town, county and state)

10. Usual Occupation Retired Carpenter

11. Industry or business

FATHER 12. Name Andrew Garnett

13. Birthplace Va.

MOTHER 14. Maiden Name Mary Page

15. Birthplace Va.

16 (a) Informant Mrs Bertha Garnett

(b) Address 4703 Pennington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/48 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location

18 (a) Funeral director E. J. Symington Jr

(b) Address 1938 E. Lafayette Ave.

19 (a) MAR 5 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/3 1948, at 7:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/14 1948, to 3/3 1948 and that I last saw h alive on 3/3 1948.

Immediate cause of death	Duration
Cardiac failure	
Typewritten CVD - arteriosclerosis	
Other significant conditions contributing to death but not related to terminal disease - senile dementia and arteriosclerosis	
Due to	
Due to	
Due to	

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature D W Mentz M. D.

Address Hagers Date signed 3/5/48

VS 150

660896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

660896 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 6-3
(d) Length of stay in hospital or inst. (yrs., mos., or days): less than 2 days
(e) Length of stay in Baltimore (yrs., mos., or days): 57 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 2320 Orleans St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Walter Franklin Williams

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Lillian Cassidy Williams
6 (c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): March 4, 1887

8. AGE: Years	Months	Days	If less than one day
60	11	28 29	hr. min.

9. Birthplace: Fredericktown, MC (Town, county, and state)
10. Usual Occupation: Master
11. Industry or business: Seafarer

FATHER
12. Name: Jonathan L. Williams
13. Birthplace: Md.

MOTHER
14. Maiden Name: Elim Mary Wilson
15 Birthplace: Delaware

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar. 6/48 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cem.
Location: Eastern Ave.

18 (a) Funeral director: John L. Miller
(b) Address: 2321 Jefferson St.

19 (a) MAR 5 1948 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5 1948, at 10:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 1 1948 to Mar. 5 1948, and that I last saw h im alive on Mar. 5 1948.

Immediate cause of death: Infarction of myocardium due to arterio-sclerotic coronary thrombosis — Duration: 3 days
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed: 3/3/48

VS 150

X

660897

BC - 48-052 OF

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 159

Registered No. 660897

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd and Calvert Sts:

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 1 day.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimor

(c) City or town 7527½ Bel Air Road (If outside city or town limits, write RURAL and give town)

(d) Street No. Baltimore County (If rural give location)

(e) Citizen of foreign country? — (Yes or No) If yes, name country —

3 (a) FULL NAME Baby Boy Viter.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single.

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 4-1948

8. AGE: Years	Months	Days	If less than one day
—	—	—	1 hr. 30 min.

9. Birthplace Baltimore - Maryland (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER

12. Name Clement Girard Viter.

13. Birthplace Baltimore

MOTHER

14. Maiden Name Grace Caroline Foster

15. Birthplace Baltimore

16 (a) Informant Father:

(b) Address 7527½ Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore Md

18 (a) Funeral director Frank Brach & Son

(b) Address 900 N. Chester St

19 (MAR 5 1948) (Date rec'd by registrar) (Signature of registrar) Washington Williamson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1948, at 7 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 . to 19 . and that I last saw him alive on March 4 1948:

Immediate cause of death Congenital Edema

Congenital Hydrocephalus

Due to Erythroblastosis

Due to R H factor negative mother R+ Positive factor father.

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

Confirmed Clinical Diagnosis

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —

(e) Means of injury —

23. Signature John S. Murray M.D.

Address 9 East Chase St. Date signed March 4-48

VS 150

X

660898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

660898 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 648 S. Decker Ave
(c) Hospital or institution: 1-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 52 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 648 S. Decker Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sebastiana Caravello

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Jack Caravello
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6 1872

8. AGE: Years	Months	Days	If less than one day
75	7	24	hr. min.

9. Birthplace St. Stefano di Camastra Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

MOTHER / FATHER
12. Name Castenzio Maiorana
13. Birthplace Italy

MOTHER
14. Maiden Name Regina Darmao
15. Birthplace Italy

16 (a) Informant Jack Caravello (Husband)
(b) Address 648 S. Decker Ave

17 (a) Burial (b) Date thereof March 6 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) MAR 5 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH March 3, 1948, at 9:22 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5, 1944, to Mar. 3, 1948, and that I last saw her alive on Mar. 3, 1948

Immediate cause of death	Duration
Acute Congestive Heart Failure	1 day
Due to Nephritis	Unknown
Diabetes Mellitus	Unknown
Due to Myocardial Damage	Unknown
Arteriosclerosis	Unknown
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Philiero Artigiani
Address 2942 E. Fayette St. Date signed 3/5/48

X

G60899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G60899

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4519 Pennington Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anton Werner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White.	Widower

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24, 1861

8. AGE: Years	Months	Days	If less than one day hr.	min.
96	11	10		1871

9. Birthplace Europe (Town, county, and state)

10. Usual Occupation Self employed

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Anton Werner
(b) Address 4519 Pennington a

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-48 (month) (day) (year)
(c) Cemetery or crematory Baden Hill
Location Baltimore Md

18 (a) Funeral director Hugh Bradshaw
(b) Address 900 N Chester St

19 MAR 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1948, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1948 to March 3 1948, and that I last saw him alive on March 3 1948.

Immediate cause of death Cerebral hemorrhage left, Duration 3 days
Respiratory failure
Due to Hypertensive arterio- sclerotic cardiovascular disease. Years (?)
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.
Address South Balto Gen Hosp Date signed Mar 4 1948

VS 150

660900 Hozey 660900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 533 N. Lafayette Ave
(c) Hospital or institution: 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 533 N. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Herman Hozey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1910

8. AGE: Years 37 | Months 9 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER 12. Name Albert A. Hozey

13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Lillian B. Miles

15. Birthplace Balto. Md.

16 (a) Informant Herbert A. Hozey

(b) Address 533 N. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Wm. George H. Holland

(b) Address 1631 Druid Hill Ave.

19 MAR 5 - 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 3 1948, at 8 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 2 1948 to Mar 3 1948, and that I last saw him alive on Mar 2 1948.

Immediate cause of death	Duration
Cardio Vascular Disease	1 yr.
Due to Broken Compensation	6 mo's
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. William Frey

Address 1928 Penna Ave Date signed 3/5/48

VS 150

X

G60901 G60901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 345 Robert St.
(c) Hospital or institution: 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 345 Robert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Stewart Cobb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 188[illegible]

8. AGE: Years 67 Months 7 Days 18 If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Cabinet maker

11. Industry or business

FATHER
12. Name William Cobb
13. Birthplace Catonsville, Md.

MOTHER
14. Maiden Name Sarah Howard
15. Birthplace Hagerstown, Md.

16 (a) Informant Mrs. Elizabeth Cobb
(b) Address 345 Robert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 6, 1948 (month) (day) (year)
(c) Cemetery or crematory Ebenezer Mem. Cem. Co.
Location Baltimore Co., Md.

18 (a) Funeral director Mrs. Eliza. A. Holland
(b) Address 1631 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 8 1948 Carlington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 2 1948, at 7:50 p.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/22 1948 to 3/2 1948, and that I last saw h[illegible] alive on 3/2 1948

Immediate cause of death: Myocardial degeneration

Due to

Due to

Other Conditions: Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frank Tim Phillips M. D.

Address 1543 Penna Ave Date signed 3/4/48

X

660902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 486

660902 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1110 RIDGELY ST

(c) Hospital or institution: 21-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 1110 RIDGELY ST (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** MARY M COOK.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM	WHITE	WIDOW

6 (b) Name of husband or wife WM. H COOK.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV 26-1853

8. AGE: Years	Months	Days	If less than one day
94	3	7	hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER

12. Name SAMUEL MAGAHA

13. Birthplace VA.

MOTHER

14. Maiden Name AGNES ROSS

15. Birthplace BALTIMORE MD

16 (a) Informant MRS AGNES SPANN

(b) Address 4503 WILKINS AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-8-48 (month) (day) (year)

(c) Cemetery or crematory MT. OLIVET.

Location FREDERICK AVE

18 (a) Funeral director Bernard C Hartke

(b) Address 131 E West St

19 (a) 1948 (b) Date received by registrar Mar 9 1948 Registrar Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 4 1948 at 6:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Septem 1947 to March 2 1948 and that I last saw h alive on March 2 1948.

Immediate cause of death Circulatory failure

Due to coronary insufficiency

Due to arteriosclerosis

Other Conditions ruptured cancer of uterus.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
about 1½ years

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. Frampton

Address 623 E. N. Avenue Date signed 3/5/48 M.D.

G60903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

Registered No. G60903

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A.
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 N. Port St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John T Russo

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Josephine Russo. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14/1877

8. AGE: Years	Months	Days	If less than one day
71	0	18	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Produce Merchant
11. Industry or business

FATHER
12. Name Salvator Russo
13. Birthplace Italy

MOTHER
14. Maiden Name unknown
15. Birthplace Italy

16 (a) Informant Mr. Joseph Russo
(b) Address 519 N. Port St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Philip Herring Sons
(b) Address 2024 Orleans St.

19 (a) MAR 5 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/3 1948, at 2.30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation by strangulation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/3/48 at about 2.00 P.M.
(b) Where did injury occur? 519 N. Port St
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Hung self to pipe in basement last night

23. Signature [signature] M.D. Medical Examiner.
Date signed 3/3/48

VS 151

G60904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓1248

Registered No. G60904

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 640 N. Schroeder St
(c) Hospital or institution: 7.5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 640 N. Schroeder St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert S. Levee Sr LEVEE

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Sep

6 (b) Name of husband or wife Grace Levee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 22, 1889

8. AGE: Years	Months	Days	If less than one day
58	4	10	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Maintenance Man
11. Industry or business American Bureau

FATHER
12. Name Jacob Levee
13. Birthplace Baltimore

MOTHER
14. Maiden Name Lonie Strohl
15. Birthplace Baltimore

16 (a) Informant Lillian Burns
(b) Address 640 N. Schroeder St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 6/48 (month) (day) (year)
(c) Cemetery or crematory Balto Cem
Location Baltimore

18 (a) Funeral director Philip Sherwood Sons
(b) Address 2024 Orleans St

19 MAR 5 - 1948 (Date rec'd by registrar) Herbert Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1948, at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1947 to 3/3 1948 and that I last saw h[illegible] alive on March 3 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Hypertensive Cardio Vascular Disease	2 years
Due to	
Other Conditions Cirrhosis of Liver	2 years

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sheldon Okeefe, M.D.
Address 244 N Milton St Date signed 3/3/48

VS 150

937

660905626 BALTIMORE CITY HEALTH DEPARTMENT 660905
CERTIFICATE OF DEATH 45F

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospital 26-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo. 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 Quail St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Martin Baczkowski
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1888

8. AGE: Years	Months	Days	If less than one day
59	4	7	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Leonard Baczkowski
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Price
15. Birthplace Germany

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Road

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 402 E. Fort Avenue St. (31)

19 (a) Date rec'd by Registrar (b) Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH March 3 1948, at 3-30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 2 1948 to March 3 1948, and that I last saw him alive on March 3 1948.

Immediate cause of death	Duration
Squamous carcinomatosis, involving mediastinal & retroperitoneal	
Due to: lymph nodes, both lungs, pleura liver, adrenals, kidneys & bones	
Due to: primary site undetermined right Tonsil	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Biopsy chest wall 2-11-48
Major findings of operation: Metastatic Squamous Carcinoma grade III
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed 3-4-48

VS 150

G60906

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH / 149a

Registered No. G60906

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 15-1
(b) Street address Greene & Redwood Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Lorman Ct # 17
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Paris J. Wilson #35012

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Negro	M

6 (b) Name of husband or wife Elmara Wilson
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1919

8. AGE: Years	Months	Days	If less than one day
29	-	3	..... hr. ..... min.

9. Birthplace Emerson, Ga.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business home

FATHER
12. Name deceased
13. Birthplace Ga.

MOTHER
14. Maiden Name Sarah Fowler
15. Birthplace Ga.

16 (a) Informant Sister
(b) Address 1605 Lorman St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof March 5, 1948 (month) (day) (year)
(c) Cemetery or crematory Atlanta Ga.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 193

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-2-48 (month) (day) 15 (year), at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-2-1948, to 3-2-1948, and that I last saw her alive on 3-2-1948.

Immediate cause of death	Duration
Due to ~~obstetrical~~ hemorrhage	
Due to ~~separation~~ ruptured ~~uterus~~ uterus	over
Other Conditions uterus (labor)	

(Include pregnancy within 3 months of death)

Date of operation 3-2-48
Major findings of operation: ruptured uterus
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John H. Lowe M.D.
Address Univ. Hosp Balto 1, Md. Date signed 3-3-48

X

C60907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C60907

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fulton Ave & Madison St

(c) Hospital or institution: Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) 69

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 195 Ellwood

(If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) **FULL NAME** Mrs Fredricka Kandzjora

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Paul Kandzjora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 29 1878

8. AGE: Years 69 | Months 3 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Robert Schauer

13. Birthplace Germany

MOTHER

14. Maiden Name Susanna Koehler

15. Birthplace Germany

16 (a) Informant Arthur Kandzjora

(b) Address 195 Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 8 (month) (day) (year)

(c) Cemetery or crematory St Paul Reformed

Location City

18 (a) Funeral director Ellicott Funeral Home

(b) Address 2008 Orleans St

19 (a) MAR 5 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/4 1948, at 2 20/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/29 1948 to 3/4 1948. and that I last saw her alive on 3/4 1948

Immediate cause of death: Cardiac + respiratory failure

Due to: Cerebral accident

Due to: Arteriosclerotic cardiovascular disease

Other Conditions: Potter

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature O. Jones Hunt

Address Maryland General Hosp Date signed 3/4/48 M.D.

VS 150

X

60908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

60908 Registered No. 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2869 Chesterfield Ave.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2869 Chesterfield Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Schumann

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Margaret Schumann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1865

8. AGE: Years	Months	Days	If less than one day
82	2	14	16 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Police-retired
11. Industry or business

FATHER
12. Name Otto W. Schumann
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia Bussman
15. Birthplace Germany

16 (a) Informant George Schumann
(b) Address 2869 Chesterfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore-Md.

18 (a) Funeral director Ullrich Funeral Home,
(b) Address 2008 Orleans St.,

19 (a) MAR 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Chesterfield Ave & Belair Rd

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1939 to Mar 3 1948 and that I last saw him alive on Mar 3 1948.

Immediate cause of death	Duration
Coronary Thrombosis	hours
Due to Hypertensive Cardio-Vascular Renal disease	years
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George S Bayley M. D.
Date signed Mar 4/48

VS 150

X

660909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 660909

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 W. Rogers Ave.
(c) Hospital or institution:
Home for the Aged of the Methodist Church
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 W. Rogers Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary King COLEMAN

3 (b) If veteran, name war: None

3 (c) Social Security Account No. --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Richard Coleman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 31, 1854

8. AGE: Years 94 | Months 1 | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: William King
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Adeline Stevens
15. Birthplace: Rock Hall, Md.

16 (a) Informant: Mrs Katharine F. Wimmer,
(b) Address: 2211 W. Rogers Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) MAR 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1948 at 6.35 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 17 1948 to Mar 3 1948 and that I last saw h.e.r alive on Mar 3 1948.

Immediate cause of death: Cardio-vascular disease — Duration: ?
Due to: Advanced arteria sclerosis — Duration: ?
Due to: Senility — Duration: ?
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Charles L. Walker M. D.
Address: 421 Med. Arts Bldg. Date signed 3/4/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

660910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660910

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Devlin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Peter Devlin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 18 86

8. AGE: Years	Months	Days	If less than one day
83	3	16	hr. min.

9. Birthplace Cumberland Md
(Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace ?

16 (a) Informant Records
(b) Address Elmhurst Home

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St

19 MAR 5 1948 (Date rec'd by registrar) Lumington for Williams, M.D. Registrar

MEDICAL CERTIFICATION 3°A

20. DATE OF DEATH March 4 – 1948, at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1942 to March 3 1948.
and that I last saw her alive on March 3 1948

Immediate cause of death Cerebral Hemorrhage
Due to Adv. arteriosclerosis
Due to
Other Conditions Chr. Nephritis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Lynch M. D.
Address 1700 Eutaw Pl. Date signed 3-4-48

VS 150

53a

660911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 660911

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4211 Arizona Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4211 Arizona Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Gillespie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1878

8. AGE: Years 69 | Months 4 3 | Days 8 9 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business

FATHER
12. Name William F. Gillespie
13. Birthplace Md

MOTHER
14. Maiden Name Adelaide Younger
15. Birthplace Md

16 (a) Informant Mary E. Gillespie
(b) Address 4211 Arizona Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Fulton Ave & Fayette St.

19 MAR 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1948, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1947 to March 4 1948. and that I last saw him alive on March 4 1948.

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions Cerebral Arteriosclerosis. Hypertension. Myocarditis.
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A. Schwartz

Address 1337 S. Clinton St. Signed 3/5/48 M.D.

VS 150

X

G60912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

G60912 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Hartford
(c) City or town Aberdeen
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Dunford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-22-00

8. AGE: Years	Months	Days	If less than one day
47	4	13	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Dunford
13. Birthplace Va.

MOTHER
14. Maiden Name Emma Ann Morse
15. Birthplace Va

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-6-48 (month) (day) (year)
(c) Cemetery or crematory Family Burying ground
Location Mitchell, Wythe Co. Va.

18 (a) Funeral director John O. Mitchell
(b) Address 900 Estaw Pl.

19 (d) MAR 5 1948 (Date rec'd by registrar) (b) Lexington Nelle Perry, M.D.

VS 150

MEDICAL CERTIFICATION

254

20. DATE OF DEATH March 4 1948, at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-17-48 to 3-4-48
and that I last saw h[illegible] alive on 3-4-1948

Immediate cause of death Cerebral thrombosis — Duration

Due to

Due to

Other Conditions Ulcerating colitis, Amebic dysentery — 5 mos.
(Include pregnancy, within three months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter A. McKusick
Address Johns Hopkins Hosp. Date signed 3/5/48

660913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 660913

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Elkins Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 W. Cold Spring La.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE M. GRAHAM

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
---	none	Female	white	widow

6 (b) Name of husband or wife Joseph Graham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1881

8. AGE: Years	Months	Days	If less than one day
66	4		hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name James Grace
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Shea
15. Birthplace Ireland

16 (a) Informant William L. Grace
(b) Address 704 Beaumont ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans & Son Inc
(b) Address 11 E. Mt. Royal Ave.

19 MAR 5 - 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1946, to March 4 1948, and that I last saw h[illegible] alive on March 1 1948.

Immediate cause of death	Duration
Carcinoma - Colon - E Metastasis	2½ yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norman R. Kenner M. D.
Address 3803 Edmondson Ave. Date signed 3/6/48

VS 150

660914 City

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 660914

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: (a) Baltimore ~~City~~, Maryland Irvington

(b) Street address 4506 Frederick Ave

(c) Hospital or institution: Colonial Nursing Convalescent Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 1947 Lafayette, E. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Kafka

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced:
Male	White	Married

6 (b) Name of husband or wife Mary Kafka

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1874

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Austria Hungary (Town, county, and state)

10. Usual Occupation Sea Food Indentity

11. Industry or business

FATHER 12. Name James Kafka

13. Birthplace Austria Hungary

MOTHER 14. Maiden Name Not Known

15. Birthplace Austria Hungary

16 (a) Informant Mary Kafka

(b) Address 1947 Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-48 (month) (day) (year)

(c) Cemetery or crematory Holy Rood Cemetery

Location Balto Md.

18 (a) Funeral director Frank Brach & Son

(b) Address

19 (a) Feb 25 48 (Date rec'd by registrar) A. W. Hebrank M.D. Registrar

MAR 5 1948 Huntington Williams, M.D.

V S 15

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24 19 48, at 12 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 19 48 to Feb 24 19 48 and that I last saw h[illegible] alive on Feb 23 19 48

Immediate cause of death Acute Congestive Heart Failure — Duration

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Emil L. Royer

Address [illegible] Date signed Feb 25 1948

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. G60915

CERTIFICATE OF DEATH

G60915CC: G94419 / 182a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 14

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 1405 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marilyn SEEMS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1947

8. AGE: Years	Months	Days	If less than one day
	3	21	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Jesse L. Seems
13. Birthplace Maryland

MOTHER
14. Maiden Name Josephine Beckus
15. Birthplace Pennsylvania

16 (a) Informant Jessie L. Seems
(b) Address 1405 Eutaw Place

17 (a) Burial (b) Date thereof 3/6/48
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director Wm Cook Inc.
(b) Address 1367 St. Paul St.

19 (a) MAR 6 1948 (b) Huntington Williams, M
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-5- 1948 at 8 55 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Mechanical suffocation

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-5-48 at 8 A. M. 14/1
(b) Where did injury occur? 1405 Eutaw Place
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Suffocation by bedclothes

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 3/5/48

VS 151

X

G60916

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 99

G60916 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 337 S. Robinson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 337 S. Robinson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Laufert

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-20-1808

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Margaret M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20th 1902

8. AGE: Years	Months	Days	If less than one day
45	9	14	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Geo. G. Laufert
13. Birthplace Poland

MOTHER
14. Maiden Name Elizabeth Byczynski
15. Birthplace Balto. Md.

16 (a) Informant Margaret E. Laufert
(b) Address 337 S. Robinson St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/8/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Sacred Heart
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) 6-1948 (Date rec'd by registrar) (b) Washington Williamsport Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4th 1948, at 12 15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/23 1947 to 3/4 1948, and that I last saw him alive on 3/4 1948.

Immediate cause of death	Duration
Cardiac Failure	
Due to Shock - following Acute Hemorrhage from Stump	
Due to Repeated Hemorrhage from Stump - following late Amputation.	
Other Conditions Buergers Disease	
Acute Heart Failure - Jan 25/1948	

(Include pregnancy within 3 months of death)
Date of operation Feb 5 1948
Major findings of operation: Gangrene - Rt foot
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Melvin D. Lamontis M. D.
Address 333 N. Eutaw Ave Date signed 3/5/48

460917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 460917

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1214 N. Chester Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 N. Chester Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Meier

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Frederick A.
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) September 9, 1861

8. AGE: Years 86 | Months 5 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Bernard Muhlek
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Muhlek
15. Birthplace Germany

16 (a) Informant Mrs. Dorothy Meyers
(b) Address 1214 N. Chester Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 6-48 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Most Holy Redeemer Cemetery

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street, Baltimore

19 (a) MAR 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH March 3, 1948 at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 26 1948 to March 3 1948, and that I last saw h[illegible] alive on March 3 1948.

Immediate cause of death: Chronic Myocarditis — Duration

Due to

Due to

Other Conditions: Senile arteriosclerosis. Pellagra.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. J. Schmitz
Address 701 N. Howard Ave. Date signed 3/4/48

VS 150

X

G60918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. G60918

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1325 Linden Avenue
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1325 Linden Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Roy W. Gibbs

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 178-01-4541

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Beatrice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1902

8. AGE: Years 45 | Months 6 | Days 12 | If less than one day ___ hr. ___ min.

9. Birthplace Pottsville, Pa.
(Town, county, and state)

10. Usual Occupation Machine Operator

11. Industry or business

FATHER
12. Name James Gibbs
13. Birthplace unknown

MOTHER
14. Maiden Name Sarah Howell
15. Birthplace unknown

16 (a) Informant Beatrice Gibbs
(b) Address 1325 Linden Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 8-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) MAR 6 - 1948 (Date rec'd by registrar) (b) Huntington for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1948, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1947 to March 5 1948 and that I last saw h[illegible] alive on March 4 1948.

Immediate cause of death carcinomatosis

Due to Carcinoma of right lung.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1 year
24 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles S Mentadt M. D.
Address 1730 Linden ave Date signed 3/6/48

X

C60919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

C60919 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2421 Marsel Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2421 Marsel Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Susan Lonella Parsley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John Edgar

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 25 1880

8. AGE: Years 67 | Months 11 | Days 9 | If less than one day hr. min.

9. Birthplace Howard Co Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name James A Carroll

13. Birthplace Howard Co Md

14. Maiden Name Sabitha E Thomas

15. Birthplace Howard Co Md

16 (a) Informant Mrs Lonnie Parsley

(b) Address 4322 Hallo Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/48 (month) (day) (year)

(c) Cemetery or crematory Dunloggin Ridge

Location Finksburg Md

18 (a) Funeral director Fulton Cox Inc

(b) Address 121 St Paul St

19 (a) MAR 6 - 1948 (Date rec'd by registrar) Washington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1948, at 3:05 P M

21. I certify that death occurred on the date stated, that I attended deceased from 1948 to 3/4 1948 and that I last saw her alive on 3/4 1948.

Immediate cause of death Pulmonary Edema — Duration sudden

Due to Chronic Myocardiachitis and myocardial degeneration — Duration 5 yrs.

Due to

Other Conditions Prolapse of uterus — Duration 2 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Urbeck, M. D.

Address 1227 Wash Blvd Date signed 3/5/48

VS 150

660920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660920

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5006 Edmondson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5006 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary A. Maxwell

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Harry F. Maxwell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 29th 1876

8. AGE: Years	Months	Days	If less than one day
71	3	4	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation House Work
11. Industry or business at Home

FATHER
12. Name James Leonard
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Anna Hafey
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Edward T. Maxwell
(b) Address 3 S. Augusta Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 (month) 8 (day) 48 (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Gowan & Son
(b) Address 902-03 Hollins St.

19 MAR 6 - 1948 (Date rec'd by registrar) (b) Waiting for Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4th 1948 at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1948 to May 4 1948 and that I last saw h[illegible] alive on May 3 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	22 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. P. Van Schaick M.D.
Address 4616 Edmondson Ave Date signed 4/6/48

X

C60921 3621199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C60921

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 715 Baker St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alex Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Married

6 (b) Name of husband or wife Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5 1899

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name	Aaron Hudnell
FATHER 13. Birthplace	Va
MOTHER 14. Maiden Name	Rose Conway
MOTHER 15. Birthplace	Records

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-48 (month) (day) (year)
(c) Cemetery or crematory Lillian Va
Location Va

18 (a) Funeral director George E. Nelson
(b) Address 1303 Pennsylvania Ave, Baltimore, Md

19 (a) MAR 6 1948 (Date rec'd by Registrar) (b) Funeral Director Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 4 1948 at 4 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1948 to Mar 4 1948 and that I last saw him alive on Mar 4 1948

Immediate cause of death	Duration
Cardiac Status	
Due to ? Coron Thrombosis	
Due to HCVD	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M Branch M. D.

Address JHH Date signed 3-5-48

VS 153

660922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 336

Registered No. 660922

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1929 E-32-St -
(c) Hospital or institution:
at Home 91
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1929 - E-32-St -
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Anne Gardner

3 (b) If veteran, name war: No
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John L. Gardner
6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Nov-9-1863

8. AGE: Years 84 | Months 3 | Days 24 | If less than one day: hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

MOTHER / FATHER

12. Name Henry Williams

13. Birthplace Ireland

14. Maiden Name Anne Graham

15 Birthplace Ireland

16 (a) Informant Miss Margaret M. Gardner

(b) Address 1929-E-32-St. -

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Mar 7-48 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore

18 (a) Funeral director Stewart Mortuary.

(b) Address 108 W North Ave.

19 (a) MAR 6 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1948, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 28 1948, to March 4 1948, and that I last saw h[er] alive on March 4 1948.

	Duration
Immediate cause of death	
Pulmonary Oedema	3 days
Due to Myocardial insufficiency + Hbp.	6 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H B Cannon M.D.

Address 2200 Garrison Blvd Date signed 3/4/48

VS 150

X

G60923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 13B

Registered No. G60923

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2566 W. Fairmount Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2566 W. Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard C Hayes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Margaret M. Metcalf
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1910

8. AGE: Years	Months	Days	If less than one day
38		24	hr. min.

9. Birthplace Mt Rainer Md.
(Town, county, and state)
10. Usual Occupation Snipper
11. Industry or business Calvert Metal Co.

FATHER
12. Name Leonard B. Hayes
13. Birthplace Ga.

MOTHER
14. Maiden Name Eva V. Clark
15. Birthplace Wash. D.C.

16 (a) Informant Wife
(b) Address 2566 W. Fairmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) MAR 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1948, at 1.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to March 3 1948, and that I last saw him alive on March 3 1948.

	Duration
Immediate cause of death Acute Myocardial Failure	1 day
Due to Pulmonary tuberculosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F. Coolahan M. D.
Address 24 N. Fulton Ave Date signed 3/4/48

VS 150

X

G60924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G60924

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1105 S.Robinson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 S.Robinson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Hamer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Carrie McFaul
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec.22,1878

8. AGE: Years	Months	Days	If less than one day
69	2	11 13	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Amer.S.& R.Co.

MOTHER / FATHER
12. Name Not Known
13. Birthplace " "
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant George Hamer
(b) Address 1105 S.Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/48 (month) (day) (year)
(c) Cemetery or crematory Mt.Carmel
Location O'Donnell St.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 Broadway

19 (a) MAR 6 - 1948 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1948 at 7:00 A-M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 8 1947 to Mar 4 1948 and that I last saw h[illegible] alive on Mar. 2 1948.

Immediate cause of death	Duration
Myocardial failure, Acute	1 Day
Due to Arteriosclerosis, Generalized	1 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Clarence W. LeDoux
Address 681 S Ellwood Ave Date signed 3/4/48 M. D.

VS 150

660925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 106 B

Registered No. 660925

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1816 N. Castle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1816 N. Castle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret B. Guy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	W

6 (b) Name of husband or wife Dixon Guy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1871

8. AGE: Years	Months	Days	If less than one day
76	4	-	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Thomas Pierce
13. Birthplace Baltimore Co. Md.

MOTHER
14. Maiden Name Ruth Corns
15. Birthplace Baltimore Co. Md.

16 (a) Informant Mrs. A. Oliver
(b) Address 1816 N. Castle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) MAR 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-4 19 48 at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 19 51 to 3-4 19 48 and that I last saw deceased alive on 3-3 19 48

Immediate cause of death	Duration
Chronic Bronchitis	5 yr.
Due to Arteriosclerosis	
Due to Senile Debility	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to ~~external causes, fill in~~ the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Pierce M.D.
Address 600 N. Bethesda Ave. Date signed 3-5-48

VS 150

660926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 660926

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 207 East 20½ Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 207 East 20½ Street
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ben Bourrough

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Florence Bourrough

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1877

8. AGE: Years	Months	Days	If less than one day
70	6	2	hr. min.

9. Birthplace Frederick, Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Phillip Bourrough

13. Birthplace Va.

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Mrs. Florence Bourrough

(b) Address 207 East 20½ Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.

Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley

(b) Address 578 W. Biddle St.

19 MAR 6 - 1948 (Date rec'd by Registrar) (Signature) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1948, at 5P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1948 to Mar 4 1948, and that I last saw h[illegible] alive on Feb 4 1948.

Immediate cause of death	Duration
Cardiac Renal Disease	5 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible] M. D.

Address 2329 Jerome St Date signed Mar 6 1948

V S 150

G60927 (duplicate) ✓ G60927 Registered No.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 321 - Pearl St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4"
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 764 - Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Holland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 3, 1915.

8. AGE: Years 32 | Months 7 | Days - | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation domestic

11. Industry or business

FATHER 12. Name Charles Holland

13. Birthplace Md.

MOTHER 14. Maiden Name Annie

15. Birthplace Md.

16 (a) Informant Pearl Brown

(b) Address 738 - Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary.

Location

18 (a) Funeral director A. Halstead

(b) Address 918 - Lemmid Hall

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-3- 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 to March 3, 1948, and that I last saw h[illegible] alive on Oct. 1, 1947.

Immediate cause of death Myocardial Insufficiency

Due to Mitral Insufficiency

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Frey, M. D.

Address 732 Eastern Pkwy Date signed 3-4-48

3-3-48 Phoned Drs. Malkin + Davis. They will OK. this certificate - LXL. Levy

60928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 60928

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address #616 W. Mulberry St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 12 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. #616 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Odessa Adams

3 (b) If veteran, name war: No

3 (c) Social Security Account No.:

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Melvin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/15/1905

8. AGE: Years 42 | Months 5 | Days 16 | If less than one day: hr. min.

9. Birthplace Lancaster, S.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Peter Reed
13. Birthplace S.C.

MOTHER
14. Maiden Name Elizabeth
15. Birthplace S.C.

16 (a) Informant Edward Gray (Son)
(b) Address 616 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/48 (month) (day) (year)
(c) Cemetery or crematory Red Hills
Location Rock Hill, S.C.

18 (a) Funeral director Charles G. Cooper
(b) Address 570-12 Camden Ar

19 MAR 6 - 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1948, at 5:35 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral Embolism

Due to Hypertension & V. Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royster M.D. Medical Examiner

Date signed 3-3-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C60929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

Registered No. C60929

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 905 E. Biddle St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 E. Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophie Robel

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife George Robel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1877

8. AGE: Years	Months	Days	If less than one day
70	3	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business at Home

FATHER
12. Name William Eachbach
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace " "

16 (a) Informant Mrs. Helen Dodge
(b) Address 905 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 8, 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd.

18 (a) Funeral director Edmund W. Conkling Son
(b) Address 924 E. Eager St.

19 (a) MAR 6 1948 (Date rec'd by local registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 4, 1948, at 12:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 11, 1947, to March 4, 1948, and that I last saw her alive on March 4, 1948.

	Duration
Immediate cause of death Secondary Carcinoma of Liver	6 months
Due to Primary adeno-carcinoma of Gall Bladder	1 Year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Sept 11, 1947
Major findings of operation: Carcinoma of Gall Bladder & Liver
of autopsy: Biopsy Taken

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William E. Gracht
Address 10 E. Preston St. Date signed 3-7-48

V S 150

C60930 GM. 116686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. C60930

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3411 Toone ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lena C. Daffin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2- 1864

8. AGE: Years	Months	Days	If less than one day
83	6	2	hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry W. Borneman
13. Birthplace Germany

MOTHER
14. Maiden Name Mary ?
15. Birthplace Germany

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore Md.

18 (a) Funeral director Wilson Work Inc.
(b) Address 2547 Pond St. Farmington Williams, Md.

19 (a) (Date received by Registrar) (b) Registrar

MAR 6 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 4 - 1948, at 7.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 - 17 - 1948 to 3 - 4 - 1948; and that I last saw her alive on 3 - 4 - 1948.

	Duration
Immediate cause of death: Bronchopneumonia Bilateral	4 days
Due to:	
Due to: Fracture, Intertrochanteric Rt Femur	34 days.
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation Feb 9 48

Major findings of operation: Fracture of Rt femur.

of autopsy: See Above.

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 26/6
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Jan 17, 1948 at M
(c) Where did injury occur? Baltimore (City or town) Md (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Fell on sidewalk While at work? at home. (Specify type of place) in front of home while sweeping
(e) Means of injury ?

23. Signature Rush C. Nutterville M. D.
Address Balt City Hosp. Date signed March 5, 1948

To Be Approved By Medical Examiner

for R. C. Nutterville M.D.
Roland Alexander M.D.

660931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

156B

Registered No. 660931

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Eaton + Wilkens

(c) Hospital or institution: Johns Hopkins Memorial

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4700 Harford Rd (If rural give location)

(e) Citizen of foreign country? USA (Yes or No) If yes, name country

3 (a) FULL NAME Pasquale Sanguedolce

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 13, 1922

8. AGE: Years	Months	Days	If less than one day
25 Yrs	3	23	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Stephen Sanguedolce

13. Birthplace Balto Md

MOTHER 14. Maiden Name Josephine Russo

15. Birthplace Balto Md.

16 (a) Informant Boy Friend

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/48 (month) (day) (year)

(c) Cemetery or crematory Loyola Cemetery

Location Baltimore Md

18 (a) Funeral director Wilson Carroll Doe

(b) Address 2174 E Fort Ave

19 (a) MAR 6 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/5 1948 at 7:08 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/ 1947 to 3/5 1948 and that I last saw him alive on 3/4 1948

Immediate cause of death	Duration
Cardiac Failure - [redacted]	
Due to Coronary Insufficiency - Heart Disease	
Due to Advanced Pulmonary Tuberculosis	
Due to Bronchiectasis	
Other Conditions Fracture - Rt humerus 2/26/48 - accidental	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence 2/26/48 at ? M

(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Hospital (Specify type of place) While at work? no

(e) Means of injury Fractured Pathologic Fracture

23. Signature D.D. Murphy M. D.

Address Stayer Date signed 3/5/48

Howard D. Mueller, M.D.

VS-150

660933 Mortimer
2706 St. Paul

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. 660932

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1301 E. North Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2706 St. Paul Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles R. Lipscomb, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-0748

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Edna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1881

8. AGE: Years	Months	Days	If less than one day
66	7	2	hr. min.

9. Birthplace Norfolk, Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles W. Lipscomb
13. Birthplace Va.

MOTHER
14. Maiden Name Alice Gregory
15. Birthplace Va.

16 (a) Informant Mrs. Edna Lipscomb
(b) Address 1301 E. North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, #14

19 (a) MAR 6 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4th 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 28 1948 to March 4 1948, and that I last saw him alive on March 4 1948.

Immediate cause of death	Duration
Coronary Thrombosis	1 hour
Due to arteriosclerosis	1 year
Due to age	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert Mortimer Jr. M. D.
Address 2706 St Paul St Date signed 3/6/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G60933

G60933 BC-48-0338 ✓ 161a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 N. Broadway
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 Short Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Dupree (395644)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/15/48

8. AGE: Years	Months	Days	If less than one day
0	0	0	6 hrs. 15 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Clarence Dupree
13. Birthplace South Carolina

MOTHER
14. Maiden Name Ernestine Brown
15. Birthplace South Carolina

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) Filed Feb 16 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15, 1948, at 11:40 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 15 1948 to Feb. 15 1948, and that I last saw her alive on Feb. 15, 1948

Immediate cause of death	Duration
Hemorrhages multiple lungs + liver	6 hrs
Due to ? Asphyxia neonatorum	6 hrs
Due to	
Other Conditions Mongol - Mother	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Newton Long M. D.
Address The Johns Hopkins Hospital Date signed 2-16-48

VS 150

660934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 660934

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cold Spring Lane
(c) Hospital or institution: Edna Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3402 Hayward Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irvin M. Baker

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	D.

6 (b) Name of husband or wife Mary Brown Baker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 21, 1899

8. AGE: Years	Months	Days	If less than one day
49	1	12	hr. min.

9. Birthplace Baltimore Co. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER
12. Name Durant W. Baker
13. Birthplace Balto. Co. Md

MOTHER
14. Maiden Name Fannie B. Young
15. Birthplace Balto Co. Md.

16 (a) Informant Mrs. Durant W. Baker
(b) Address 3402 Hayward Ave

17 (a) Burial (b) Date thereof 3-6-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory All Saints Church Cem.
Location Reisterstown, Md.

18 (a) Funeral director Leroy Beyer
(b) Address 5005 Park Heights Ave

19 (a) MAR 6 - 1948 (Date rec'd by registrar) (b) Huntington, W. Va. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4, 1948, at 7 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1947, to March 1948, and that I last saw him alive on March 3 1948.

Immediate cause of death	Duration
Chronic Myocarditis	5 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R. Klenman, M.D.
Address 3803 Edmondson Ave Date signed 3/5/48

V S 150

660935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1473

Registered No. 660935

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N Calhoun St
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1343 Poplar Grove St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred E. Dischen

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife August Dischen Jr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16-1922

8. AGE: Years	Months	Days	If less than one day
26	-	17	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Albert Krausch
13. Birthplace Md.

MOTHER
14. Maiden Name Lina Jones
15. Birthplace Md.

16 (a) Informant August W. Dischen Jr.
(b) Address 1343 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director George L. Schwab
(b) Address 2101 Fredrick Ave.

19 (a) MAR 6 - 1948 (Date received by registrar) (b) Signature for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1948, at 5:09 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/3 1948, to 3/4 1948, and that I last saw her alive on 3/4 1948.

Immediate cause of death: Sarcoma Colloyde — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. Williams M.D.
Address Franklin Sq Hosp Date signed 3/4/48

X

BALTIMORE CITY HEALTH DEPARTMENT

660936 BC-B6850 CERTIFICATE OF DEATH 104a Registered No. 660936

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1301 Wirton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
9 City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 Wirton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward L. Edwardson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21-1947

8. AGE: Years	Months	Days	If less than one day
1	1	13	hr. min.

9. Birthplace Balto, Md.
(Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER 12. Name Edward Edwardson

13. Birthplace N.Y.

MOTHER 14. Maiden Name Eileen Nica

15. Birthplace Md.

16 (a) Informant Mrs. Edw. Edwardson

(b) Address 1301 Wirton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/48 (month) (day) (year)

(c) Cemetery or crematory Moreland

Location Md

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Harford Rd.

19 (a) MAR 6 - 1948 (Date rec'd by registrar) (b) [illegible] for Miriam, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 19 48, at 9:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Upper respiratory infection

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.

Date signed 3/4/48

VS 151

1660937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8 3a

Registered No. 1660937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2513 W. Fayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2513 W. Fayette St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes R Sheeran

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23rd 1896

8. AGE: Years	Months	Days	If less than one day
51	11	11	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation House Work

11. Industry or business at Home

FATHER
12. Name William Sheeran
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary A. Hodges
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Charles A. Dietrich
(b) Address 2513 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 (month) 9 (day) 48 (year)

(c) Cemetery or crematory London Park Cem
Location 3801 Frederick Ave

18 (a) Funeral director John J. Gowan & Son
(b) Address 701-03 Hollins St.

19 (a) MAR 5 1948 (Date rec'd by Registrar) (b) Huntington Williams (Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5th 1948, at 9 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1946 to March 5 1948, and that I last saw her alive on 5 March 1948

Immediate cause of death	Duration
Cerebral accident	10 hrs.
Due to Hyper tension	—
Due to	
Other Conditions Cardiac Decline	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Vogel Jr. M. D.
Address 2601 E. Fairmount Ave Date signed 6 March 48.

G60938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G60938 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 GARRISON BLVD.
(c) Hospital or institution: GARRISON NURSING HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2606 TALBOT RD. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EMMA GEORGE DAVIS

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	M	WIDOWED

6 (b) Name of husband or wife ULMER W. DAVIS. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUL. 25, 1863

8. AGE: Years	Months	Days	If less than one day
84	7	10	hr. min.

9. Birthplace WALTERBORO, S. C. (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

MOTHER / FATHER
12. Name SAXBY CHAPLIN
13. Birthplace S. CAROLINA.
14. Maiden Name ANNE O. H. WITTELL
15. Birthplace S. C.

16 (a) Informant MR. S. CHAPLIN DAVIS (SON)
(b) Address 2606 TALBOT RD.

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 3/6/48 (month) (day) (year)
(c) Cemetery or crematory LIME OAK
Location WALTERBORO, S. C.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTIMORE, MD.

19 (a) — 1948 (Date rec'd by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 6 1948, at 9 15/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/21 1946 to 3/5 1948 and that I last saw her alive on 3/2 1948.

Immediate cause of death	Duration
Myocardial insufficiency	1 hr.
Due to Arteriosclerosis	?
Due to Senility	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert A. Reiter
Address 3401 Wunderlich Date signed 3/6/48.

VS 150

Thurlington Williamson

X

C60939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

C60939 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (~~yrs.~~, ~~mos.~~, or days) 8
(e) Length of stay in Baltimore (~~yrs.~~, ~~mos.~~, or days) 8

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County York
(c) City or town Delta
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MR. NEWTON M. SCARBOROUGH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife Katherine G.
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Feb 26 1887

8. AGE: Years	Months	Days	If less than one day
61		9	hr. min.

9. Birthplace Harford Co. Md
(Town, county, and state)

10. Usual Occupation Merchant
11. Industry or business

FATHER
12. Name Jos Scarborough
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Mary Yaske
15. Birthplace Delta Pa

16 (a) Informant N. M. Scarborough Jr.
(b) Address 1421 - 4th Ave York Pa.

17 (a) Burial (b) Date thereof 3 (month) 10 (day) 48 (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Slate Ridge
Location York Co. Pa.

18 (a) Funeral director Hubert P. Perkins
(b) Address Delta, Pa.

19 (a) 3-10-1948 (b) Thornton Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1948, at 405 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-28 1948 to 3-6 1948, and that I last saw him alive on 3-6 1948

Immediate cause of death	CARDIAC FAILURE	
Due to	CORONARY THROMBOSIS	
Due to	Hypertensive C-V. Disease	
Due to	Chronic Nephritis	
Other Conditions	Irregular Anemia - (Cause undetermined)	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Gordon Manson Jr. M.D.
Address Md. Gen. Hosp. Date signed 3-6-48

VS 150

C60940

BALTIMORE CITY HEALTH DEPARTMENT ✓ C60940 Registered No.

CERTIFICATE OF DEATH 82

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2510 W Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2510 W Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George KALINAUSKAS (KALIN)
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M Female	W	Married

6 (b) Name of husband or wife Constance
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Lith. (Town, county, and state)
10. Usual Occupation Retire
11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith.

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant Constance Kalinauskas
(b) Address 2510 W Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Belair Rd.

18 (a) Funeral director Joseph Kasenskas Jr.
(b) Address 602 Washington Blvd.

19 (a) MAR 7 1948 (Date filed by registrar) (b) Thomas Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1948 at 2:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/29 1948 to 3-4 1948 and that I last saw h[illegible] alive on 3-4 1948

Immediate cause of death	Duration
Chronic myocarditis and myocardial degeneration	6 months
Due to	
Due to	
Other Conditions Syringomyelia	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John P. Ulrich, Jr. M.D.
Address 1227 Wash. Blvd. Date signed 3/5/48

937

VS 150

G60941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G60941 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 101 W. Clement St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 101 W. Clement St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary E. Mc Curdy

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife John A. Mc Curdy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1 - 1867

8. AGE: Years 80 | Months 4 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Dennis Butler
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Joseph P. Mc Curdy
(b) Address 1505 Riverside Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Flynn - Fleming
(b) Address 426 Light St.

MAR 7 1948

19 (a) (Date rec'd by registrar) (b) Registrar

Huntington-Williams, Inc.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1948, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1948, to 3/4 1948
and that I last saw h[illegible] alive on 3/4 1948.

Immediate Cause of death	Duration
(a) Coronary Thrombosis	1/2 hr.
Due to (b) Arteriosclerosis	2 yrs.
Due to (c) Hypertension Cerebral	1 yr.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. D. Mellette M. D.

Address 1279 Hilldale Rd Date signed 3/6/48

G60942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G60942
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1226 S. Decker Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1226 S. Decker Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Holewinski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Michael

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Penna.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George
13. Birthplace Checo Slovakia

MOTHER
14. Maiden Name anna Durisin
15. Birthplace Lehero Slovakia

16 (a) Informant Michael Holewinski
(b) Address 1226 S Decker Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill road.

18 (a) Funeral director Stephen J. Fialkowski Inc
(b) Address 1000 S. Kenwood ave

19 (a) (Date rec'd by registrar) (b) Huntington Nottingham Registrar

MAR 7 - 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1948, at 5:30 p.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 10 1947, to March 3 1948, and that I last saw her alive on March 3 1948.

	Duration
Immediate cause of death: Cerebral Haemorrhage	ab. 3 hr.
Due to: Essential Hypertention	Unknown
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. A. Rosenblatt M. D.
Address 308 O'Donnell St. Baltimore-24, Md. Date signed 3-4-48

G60943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G60943 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 N. Chester St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 N. Chester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Barbara Weaver

3 (b) If veteran, name war No

3 (c) Social Security Account No. None

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24 1873

8. AGE: Years 75 | Months — | Days 11 | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

MOTHER FATHER
12. Name Conrad Nagengast
13. Birthplace Germany?
14. Maiden Name Mary
15. Birthplace Germany

16 (a) Informant Carrie Armstrong
(b) Address 3234 Belair Rd

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** MAR 8 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location 4420 Belair Road.

18 (a) Funeral director The Dippel Bros.
(b) Address 1800 E. Lombard St.

19 (a) MAR 9 1948 (Date received by registrar) (b) Huntingtown, Williamsville

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1948, at 11:15 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1948 to March 5 1948, and that I last saw h[illegible] alive on March 5 1948

Immediate cause of death	Duration
Coronary Myocardial Arteriosclerosis with Pulmonary Edema	
Due to Chr. Hypertension + Cardio-vascular disease ?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Emmett Semmes M. D.

Address 5002 Harford Ave Date signed 3/5/48

VS 150

660944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

660944 ✓ Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. General Hosp. 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 136 Willard Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William OTTO

3 (b) If veteran, name war

3 (c) Social Security Account No. 245-09-4085

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Emma A. Otto

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) October 14-1875

8. AGE: Years 72 | Months 4 | Days 19 | If less than one day hr. 23 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Bookkeeper

11. Industry or business Mandey Packing Co

FATHER
12. Name Louis Otto
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Louis H. Otto
(b) Address 136 Willard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director F. A. Kippot-Sons
(b) Address Baltimore Maryland
Embalmer Wilson Williams, M.D.

19 (a) MAR 7 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-5-1948 at 10 A.M. 05

21. I certify that I took charge of the remains described above, held an Inspection & Inq. Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 3/5/48

VS 151

G60945

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G60945
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20 N. Monroe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 20 N. Monroe St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ESTELLA E. PHIPPS

3 (b) If veteran, name war ////////// | 3 (c) Social Security Account No. //////////

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Harry C. Phipps
6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr) May 30, 1870

8. AGE: Years	Months	Days	If less than one day: hr.	min.
76	9	3 5		184

9. Birthplace St. Mary's Co. Md.
(Town, county, and state)
10. Usual Occupation Housewife At
11. Industry or business Home

FATHER
12. Name ? Caywood
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Maryland

16 (a) Informant Charles S. Phipps
(b) Address 5007 Overton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 8th/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Maryland

18 (a) Funeral director F. B. WIPPERT & SON
(b) Address 1300 EUTAW PLACE

19 (a) MAR 1 1948 (Date rec'd by registrar) (b) Lexington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 4th. 1948 6:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 1947 to 3/4 1948 and that I last saw her alive on 3/3 1948.

	Duration
Immediate cause of death Myocardial Infarction	2 days
Due to Arteriosclerotic Cardiovascular Disease	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John P. Urlock, Jr. M. D.
Address 1227 Washington Blvd Date signed 3/ /48

VS 150

Dr. Urlock. X

660946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

660946 Registered No. 92a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 10 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days): 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country:

3 (a) FULL NAME: William O'Brien

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No.: 579-01-9258

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 12, 1886

8. AGE: Years: 61 | Months: 5 | Days: 21 | If less than one day: 3 hr. min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual Occupation: Painter

11. Industry or business:

FATHER
12. Name: Dennis O'Brien
13. Birthplace: Washington, D.C.

MOTHER
14. Maiden Name: Mary O'Conner
15. Birthplace: Washington, D.C.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location: Washington D.C.

18 (a) Funeral director: Elizabeth Armacost
(b) Address: 3911 Liberty Heights Ave.

19 (a) 1948 (Date rec'd by registrar) Registrar

MAR

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5 1948, at 3:17 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 4 1948 to Mar. 5 1948, and that I last saw him alive on Mar. 5 1948.

Immediate cause of death	Duration
Infarction of myocardium due to arteriosclerotic coronary thrombosis	
Due to arteriosclerotic heart disease	
Due to	
Other Conditions aortic valvular disease regurgitation	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: J. Lewis, Jr. MD M. D.
Address: US Marine Hospital Baltimore, Md. Date signed: March 1948

660947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

660947 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. Bond & Main
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry S. Roop

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20 1861

8. AGE: Years	Months	Days	If less than one day
86	2	16	hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation Ret. House Owner

11. Industry or business

FATHER
12. Name Daniel J. Roop
13. Birthplace Md.

MOTHER
14. Maiden Name Henrietta Ocker
15. Birthplace Md.

16 (a) Informant Hospital records.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 10-1948 (month) (day) (year)
(c) Cemetery or crematory Westminster Cem.
Location Westminster, Md.

18 (a) Funeral director Jr. Francis Reese
(b) Address Westminster, Md.

19 MAR 8- 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1948, at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1948 to 3/7 1948, and that I last saw him alive on 3/7 1948.

Immediate cause of death	Duration
Bilateral Bronchopneumonia	10 days.
Due to Uremia	10 days
Due to Arteriosclerotic Cardiovascular Renal Disease	? years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alfred H. Dann M. D.
Address Maryland General Hosp. Date signed 3/7/48

G60948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

99 ✓

Registered No. G60948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ACTUAL SIGNATURE REQUIRED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23 N. Caldwell St.
(c) Hospital or institution: Union Memorial Hospital 9-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days.
(e) Length of stay in Baltimore (yrs., mos., or days) — Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4054 Hillen Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Sidney L. Jamison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Thomas Jamison
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/20/1875

8. AGE: Years	Months	Days	If less than one day
72	10	15/6	hr. min.

9. Birthplace Wheeling, W. Virginia
(town, county, and state)

10. Usual Occupation Companion

11. Industry or business

FATHER
12. Name Benjamin Bird
13. Birthplace W. Virginia

MOTHER
14. Maiden Name Elizabeth McCracken
15. Birthplace W. Virginia

16 (a) Informant William L. Cotton, nephew
(b) Address 4054 Hillen Road

17 (a) Removal (b) Date thereof 3/7/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Wheeling W Va

18 (a) Funeral director Pelham & Jackson Sons
(b) Address North & Pendleton Sts

19 MAR 8- 1948 (b) Huntington West Virginia
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1948, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/3 1948 to 3/6 1948 and that I last saw h[illegible] alive on 3/6 1948.

Immediate cause of death	Duration
Coronary occlusion	
Due to Arteriosclerotic heart disease	— Years
Due to Chronic auricular fibrillation	> 1 year
Due to Mesenteric thrombosis requiring massive resection	4 d.
Other Conditions Generalized intestinal	

(Include pregnancy within 3 months of death)

Date of operation 3/3/48

Major findings of operation: Mesenteric thrombosis of small intestine

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fay Martin Fox

Address Union Memorial Hospital Date signed 3/6/48

VS 150

X

660949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

660949 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-2 $33 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore # 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 313 E. 30th. St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Winfield Scott Wolfe

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 18-1861

8. AGE: Years 86 | Months 2 | Days 18 | If less than one day 20 hr. min.

9. Birthplace Uniontown, Md. (Town, county, and state)
10. Usual Occupation Lumber dealer
11. Industry or business Retired

FATHER
12. Name Joseph Wolfe
13. Birthplace Md.

MOTHER
14. Maiden Name Adeline Hyder
15. Birthplace Md.

16 (a) Informant James Wolfe (son)
(b) Address 313 E. 30th St. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/10/48 (month) (day) (year)
(c) Cemetery or crematory Mountain View Cem
Location Union Bridge, Md.

18 (a) Funeral director W. H. Hartsock & Sons
(b) Address Union Bridge & New Windsor, Md

19 MAR 8 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-7 1948, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-3 1948 to 3-7 1948, and that I last saw h[illegible] alive on 3-7 1948

Immediate cause of death: Cardiac failure — Duration: 2 days
Due to
Due to
Other Conditions: Post-operative perineal prostatectomy — 2 day
(Include pregnancy within 3 months of death)
Date of operation 3-6-48
Major findings of operation: Benign prostatic hypertrophy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert Johnson M. D.
Address Mercy Hospital Date signed 3-7-48

VS 150

60950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G60950

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2840 ELLICOTT DR.

(c) Hospital or institution: 16-7

ABOVE ADDRESS

(d) Length of stay in ~~hospital or inst. (yrs., mos., or days)~~ 1½ YRS

(e) Length of stay in Baltimore (yrs., mos., or days) 18 YRS

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2840 ELLICOTT Dr.

(If rural give location)

(e) Citizen of foreign country? — (Yes or No)

If yes, name country

3 (a) FULL NAME ELLA R. TAYLOR

3 (b) If veteran, name war No.

3 (c) Social Security Account No. NONE

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife JOHN B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 16, 1865

8. AGE: Years 82 | Months 9 | Days 19 | If less than one day 20 hr. min.

9. Birthplace TYASKIN, MD.

(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business @ HOME

FATHER 12. Name CHARLES W. LARMORE

13. Birthplace TYASKIN, MD.

MOTHER 14. Maiden Name REBECCA JARRETT

15. Birthplace TYASKIN MD.

16 (a) Informant MISS ORA TAYLOR

(b) Address 2840 ELLICOTT DR.

17 (a) BURIAL (b) Date thereof 3/8/48

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory TYASKIN METH.

Location TYASKIN, MD.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address BALTIMORE MD.

19 MAR 8 - 1948 (Huntington Williams M.D.)

(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 5 1948, at 8 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1947 to MAR 5 1948 and that I last saw her alive on MAR 1 1948.

	Duration
Immediate cause of death: Myocarditis and Dilatation of Heart	✓
Due to	
Due to: General Arteriosclerosis	✓
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide ✓

(b) Date of occurrence ✓ at ✓ M

(c) Where did injury occur? ✓ ✓ ✓

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work?

(Specify type of place)

(e) Means of injury ✓

23. Signature Helen A. Taylor M.D.

Address 1219 Pelham Ave Date signed 3/6/48

G60951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82

Registered No. G60951

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Oata & Wilson
(c) Hospital or institution: Johnson Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Va~~ (b) County –
(c) City or town Williamsburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Ballard Peebles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27 1910

8. AGE: Years	Months	Days	If less than one day
37	9	9	hr. min.

9. Birthplace Williamsburg Va.
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business NONE

FATHER
12. Name A. B. Peebles.
13. Birthplace Virginia

MOTHER
14. Maiden Name Gertrude Kyle
15. Birthplace Virginia

16 (a) Informant MRS. RUTH B. PEEBLES
(b) Address ARLINGTON, VA.

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof MARCH 8, 1948 (month) (day) (year)
(c) Cemetery or crematory CEDAR GROVE
Location WILLIAMSBURG, VA.

18 (a) Funeral director WILLIAM COOK, ENG
(b) Address 1217 ST. PAUL ST

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6 1948, 10:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1947 to 3/6 1948 and that I last saw h[illegible] alive on 3/6 1948.

	Duration
Immediate cause of death Cardiac failure – Uremia – Pneumonia –	
Due to Ascending Thrombosis & Gangrene of Left Leg	
Due to Fracture Cervical Vertebrae & Cord injury in 1926	
Other Conditions (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. W. Minter M. D.
Address Hayes Date signed 3/7/48

VS 150

G60952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G60952

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore md
(b) Street address 306. N. Stricker St
(c) Hospital or institution: 19-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED: Baltimore
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 306. N. Stricker St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ned Harris

3 (b) If veteran, name war

3 (c) Social Security Account No. 093-12-0168

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col.	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15. 1920

8. AGE: Years	Months	Days	If less than one day
28 yrs	7	21	hr. min.

9. Birthplace N. Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Samuel Harris
13. Birthplace N. C.

MOTHER
14. Maiden Name Lydia Vincent
15. Birthplace N. C.

16 (a) Informant Carrie Squire
(b) Address 306. N. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/48 (month) (day) (year)
(c) Cemetery or crematory Church Cemetary
Location Pertalia Chapel. N. C.

18 (a) Funeral director Metropolitan Funeral Homes
(b) Address 922. N. Mont St

19 MAR 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/5/48 19 at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/2/48 19 to 3/4/48 19 and that I last saw h alive on 3/4/48 19

Immediate cause of death Lobar Pneumonia — Duration Several days

Due to Exhaustion

Due to " "

Other conditions Complicating Pregnancy

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature H. L. Pasmakola M. D.
Address 5 E. Lexington St (Title signed) 3/6/48

VS 150

660953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660953

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: N. Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 1 day
(e) Length of stay in Baltimore (yrs., mos., or days): 3 wks

2. USUAL RESIDENCE OF DECEASED:
(a) State: Illinois (b) County: Chicago
(c) City or town: Chicago (If outside city or town limits, write RURAL and give town)
308-W-109th Street (d) Street No.: 773 Aberdeen Pl. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) **FULL NAME**: Mrs. Margaret Jackson
3 (b) If veteran, name war: None
(c) Social Security Account No.: - ? -
4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: Lawrence Jackson
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Dec. 9. 1882
8. AGE: Years: 65 Months: 2 Days: 27 If less than one day: 29 hr. min.
9. Birthplace: Scotland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

MOTHER / FATHER
12. Name: Thomas Gibbon
13. Birthplace: Scotland
14. Maiden Name: Margaret Telford
15. Birthplace: Scotland

16 (a) Informant: Mrs. Lawrence Jackson
(b) Address: 913 Aberdeen Pl. (12)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3-8-48 (month) (day) (year)
(c) Cemetery or crematory: Cedar Park
Location: Chicago - Ill.

18 (a) Funeral director: Silvester Morse Co.
(b) Address: 108 W. Monroe St.

19 MAR 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/7/48 19 , at 5 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6/48 19 to 3/7/48 19 ; and that I last saw [her] alive on 3/7/48 19 .

Immediate cause of death
(a) Cerebral apoplexy
Due to (b) 3 previous cerebral hemorrhages accidents
Due to (c) Arteriosclerosis - Hypertension
C.V. disease

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration
5-10 yrs ago

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: J. D. Watson
Address: Church Home Hosp. Date signed: 3/7/48

VS 190

G60954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G60954

48-04916 159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: L. J. Josephs Hospital 6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 230 N. Washington St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Hearthy Sullivan Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/5/48

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Hearthy Sullivan,
13. Birthplace Baltimore

MOTHER
14. Maiden Name Dillon,
15. Birthplace Portsmouth, Ohio

16 (a) Informant Father.
(b) Address 230 N. Washington St.

17 (a) Burial (b) Date thereof March 8
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location City

18 (a) Funeral director Leissick Funeral Home
(b) Address 2008 Eutaw St.

19 (a) MAR 8 - 1948 (b) Interred for Williamsville, Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/7 1948, at 2:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5 1948 to 3/7 1948 and that I last saw him alive on 3/7 1948

	Duration
Immediate cause of death: Respiratory failure	Imm.
Due to: Prematurity	2 days
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James S. Steele M. D.
Address L. J. Josephs Hosp. Date signed 3/7/48

VS 150

660955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No. 660955

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2608 Orleans St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lewell J Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Roberta Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29. 1869

8. AGE: Years	Months	Days	If less than one day
78	6	7	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation R. R. Man

11. Industry or business

FATHER
12. Name Benj Johnson
13. Birthplace Md

MOTHER
14. Maiden Name America Ward
15. Birthplace Md

16 (a) Informant Miss Minnie Johnson
(b) Address 2608 Orleans St

17 (a) Burial (b) Date thereof Mar 9.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bakr Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date received) MAR 8 1948 (b) Huntingtown Williamsport, Md

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4 Mar 1948 to 5 March 1948, and that I last saw h alive on 5 March 1948.

Immediate cause of death

Cardio-Respiratory Failure

Due to Hypertension C.V.D.

Due to

Other Conditions Incarcerated Hernia

(Include pregnancy within 3 months of death)

Date of operation 4 March 48

Major findings of operation: Incarcerated Hernia

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Philip H. Lerman M.D.
Address Sinai Hospital Date signed 8 March 48

X

660956 Say 3511 D.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. 660956

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1575 Aliceston St
(c) Hospital or institution: Allendale 4-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1575 Allendale St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes name country

3 (a) FULL NAME Jacob Shafe
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6 1860

8. AGE: Years 87 88 | Months 10 | Days — | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county and state)
10. Usual Occupation School Teacher
11. Industry or business Retired

FATHER
12. Name Jacob Shafe
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Leasard
15. Birthplace Balto. Md.

16 (a) Informant Miss Grace Shafe
(b) Address 505 Arlington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount & Oliver

18 (a) Funeral director John A. McKean
(b) Address 1201 Greenmount Ave

19 (a) MAR 8 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/3/48 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 25 1947 to March 3 1948, and that I last saw h alive on March 3 1948

Immediate cause of death Pneumonia Bronchiectasis — Duration 7 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm D Hunt
Address 701 N. Howard St. Date signed 3/4/48 M.D.

VS 150

X

G60957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G60957

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2724 N Charles St.
(c) Hospital or institution: Doctors Hospital 13 1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 9½ yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 830 Chauncey Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jacob Lamm
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Auguste
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years	Months	Days	If less than one day
87			hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Lazar
13. Birthplace Germany

MOTHER
14. Maiden Name Bettie
15. Birthplace Germany

16 (a) Informant Leo Lamm
(b) Address 830 Chauncey Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd. Hamilton Ave
18 (a) Funeral director Jas. L. Lewis Inc
(b) Address 2100 Eutaw Place
19 [redacted] 1948 Huntington Williams, MD
Date rec'd by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/7 1948 at 1:15 a.M
21. I certify that death occurred on the date above stated; that I attended deceased from 2/28 1948 to 3/7 1948, and that I last saw h[illegible] alive on 3/7 1948

Immediate cause of death	Duration
Heart failure	
Due to Hypertensive arteriosclerotic C.V. disease	
Due to	
Other Conditions Bronchopneumonia Hypertensive A.C. Encephalopathy (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Robert K. Lowen M. D.
Address 2724 N Charles St. Date signed 3/7/48

VS 150

660958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 660958

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 236 - Dolphin St

(c) Hospital or institution: 11-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 236 - Dolphin St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Mary Wilson ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15 1898

8. AGE: Years 49 | Months 3 | Days 19 | If less than one day hr. min.

9. Birthplace Greenwood, S.C.

(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Thomas Anderson

13. Birthplace Greenwood S.C.

MOTHER 14. Maiden Name ? Jackson

15. Birthplace Greenwood S.C.

16 (a) Informant Janie Golden

(b) Address 236 - Dolphin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location A. Halstead

18 (a) Funeral director

(b) Address 918 - Druid Hill

19 (a) MAR 8 - 1948 (Date rec'd by registrar) Huntington Williamsport. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/4/1948, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1948 to 3/4 1948 and that I last saw h[illegible] alive on 3/4 1948.

Immediate cause of death Lobar Pneumonia — Duration 4 Days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature B. N. Hofstetter

Address 1745 Pa. Ave. Date signed 3/6/48

VS 150

X

660959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. 660959

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1214 E.Lafayette Avenue
(c) Hospital or institution:

9-9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 E.Lafayette Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Katie E.Kampe

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John Louis Kampe
6 (c) If alive, give age (D) years

7. Birth date of deceased (mo., day, yr.) Jan.13th.,1865

8. AGE: Years 83 | Months 1 | Days 22 23 | If less than one day: ######## hr. ..... min.

9. Birthplace Baltimore,Maryland
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name ? Bruck
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Andrew R.Kampe (Son)
(b) Address 1202 E.Lafayette Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location E.North Avenue,Balto:Md.

18 (a) Funeral director George J.Ruth,Inc.
(b) Address 1735 Harford Avenue

19 (a) MAR 8 - 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5th., 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1948, to March 5 1948, and that I last saw him alive on Mar 5 1948.

Immediate cause of death	Duration
Cerebral Hemiplegia	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Theresa L Kampe
Address 1761 E Mra Date signed 3/10/48 M.D.

V S 150

X

660960 Kopper ✓ 83a 660960

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 715 Streeper Street
(c) Hospital or institution: 7-
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 715 Streeper Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME George P.B.Kopper

3 (b) If veteran, name war None

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen Herberich

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27th., 1873

8. AGE: Years	Months	Days	If less than one day
74	3	10	##### hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name George Kopper
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Snyder
15. Birthplace Germany

16 (a) Informant Mrs. Helen Kopper (Wife)
(b) Address 715 Streeper Street

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 3/10/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 MAR 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7th., 19 48 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-30-46 19 to 3-7- 1948, and that I last saw h[illegible] alive on 3-7- 19 48

Immediate cause of death	Duration
Cerebral hemorrhage	3 days
Due to Hypertension	2 years
Due to Arteriosclerosis	2 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benj. B. Turner, M.D.
M. D.
Address 448 N. Ledgerwood Ave. **Date signed** 3-8-48

V S 150

X

660961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 660961

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 101 Woodlawn Road
(c) Hospital or institution: 27 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 101 Woodlawn Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nelle Stuart Todd

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Dr Frederick P. Todd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch 18. 1867

8. AGE: Years 80 | Months 11 | Days 18 | If less than one day: hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Alexander Steuart
13. Birthplace Scotland

MOTHER
14. Maiden Name Elizabeth Patsch
15. Birthplace Ohio

16 (a) Informant Florens C. Losey
(b) Address 101 Woodlawn Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 8. 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell Sons Co.
(b) Address 1900 Eutaw Place

19 (a) MAR 8 1948 (Date received by registrar) (b) Huntington Wilson, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6. 1948 19 , at 2.4 M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 3 1948 to Mar 6 1948, and that I last saw h[illegible] alive on March 2 1948.

Immediate cause of death	Duration
My cerebral hemorrhage	24
Due to Arterial sclerosis	2
Due to [illegible]	
Other Conditions (Nov. 46-47)	Brain Nov 46-47

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27 14
(a) Accident, suicide, or homicide Accident Mar 30. 47
(b) Date of occurrence 11-30-47 at M
(c) Where did injury occur? Home - 101 Woodlawn Rd (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? Fell out
(e) Means of injury Fell out of Bed

23. Signature Homer J. Hawkins, M.D.
Address 3429 Chestnut Ave. Date signed 3-8-48

660962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

660962

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State DC (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 3502 30th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ruth Van Deman
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. S
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 22, 1888
8. AGE: Years 59 | Months 58 | Days 5 | If less than one day hr. min. 14
9. Birthplace Kansas (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Henry Van Deman
13. Birthplace Ohio
14. Maiden Name Anna McCormey
15. Birthplace Ill

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof March 8/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3861 Fredericksburg Ave

18 (a) Funeral director John D. Mitchell & Sons
(b) Address 1600 Eutaw Place

19 (a) MAR 8 1948 (Date rec'd by registrar) (b) Signature for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-6- 1948 at 3P M

21. I certify that death occurred on the date above stated, that I attended deceased from 1-29- 1948 to 3-6- 1948 and that I last saw h[illegible] alive on 3-4- 1948

Immediate cause of death Carcinomatosis

	Duration
Due to Ca of breast	6 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 1941
Major findings of operation: Ca
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry T. Bahrenburg M.D.
Address JNH Date signed 3/7/48

G60963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G60963

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Payson & Fayette Sts
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 ds
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1517 McHenry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE M. DEE

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Thomas J. Dee

6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Sept 23 1873

8. AGE: Years 74 | Months 5 | Days 14 | If less than one day 15 hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name ?

13. Birthplace

MOTHER 14. Maiden Name ?

15. Birthplace

16 (a) Informant Thomas J. Dee

(b) Address 1517 McHenry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 11, 1948 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Rt 40 & B.M. Walks

18 (a) Funeral director Pratt & Hucker

(b) Address

19 (a) MAR 8 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1948, at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1948, to March 8 1948, and that I last saw her alive on March 7 1948

Immediate cause of death: Cerebral arteriosclerosis & pneumonia — Duration: 5 years ?

Due to: Essential hypertension

Due to:

Other Conditions: 1. Fracture of hip 2. Decubitus ulcers — Duration: 6 wks

(Include pregnancy within 3 months of death)

Date of operation Jan 19, 1948

Major findings of operation: Fracture right hip

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 19

(a) Accident, suicide, or homicide Accident contributory

(b) Date of occurrence Jan. 2, 1948 at 8:45 P.M.

(c) Where did injury occur? Baltimore, Baltimore, Maryland (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? at home While at work? No
(Specify type of place)

(e) Means of injury Fell off a chair

23. Signature Walter B. Granger,

Address Bon Secours Hospital Date signed 3/8/48

Homer J. Dawson, M. D.

VS 150

660964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

147 B

Registered No. 660964

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1532 N. Washington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1532 N. Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence (Marcirella) Mosciella

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-12-9042

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: August J.

6 (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.): November 9, 1923

8. AGE: Years: 24 | Months: 3 | Days: 25 | If less than one day: hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: Rolf W. Finnick
13. Birthplace: Balto Md

MOTHER
14. Maiden Name: Mary R. Beyer
15. Birthplace: Balto Md

16 (a) Informant: August J. Mosciella
(b) Address: 1532 N. Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: March 8, 1948 (month) (day) (year)
(c) Cemetery or crematory: Oaklawn Cem
Location:

18 (a) Funeral Director: H. H. & B. M. Walker
(b) Address: Pratt & Chucker Sts

19 (a) MAR 8 1948 (Date rec'd by registrar) (b) Huntington Ave Baltimore Md

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1948, at 2.45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Acute dilatation of heart

Due to: Acute endometritis due to Retained portions of placenta over

Other Conditions: ~~Incomplete abortion~~ Postpartum

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Earl Royer M.D. (Medical Examiner)
Date signed 3-5-48

VS 151

X

G60965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G60965

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3920 Fait Ave.
(c) Hospital or institution: 26-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3920 Fait Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George W. Greensfelder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1876

8. AGE: Years	Months	Days	If less than one day
71	7	22	24 hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Baltimore

MOTHER
14. Maiden Name Anna V. Owens
15. Birthplace Baltimore

16 (a) Informant Mrs. Winnie Rossmark
(b) Address 3920 Fait Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/10/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) Mar 8 1948 (b) [illegible] Registrar

Filed by registrar for Williams Mar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 Mar. 1948, at 6:05 P. M.

21. I certify that I took charge of the remains described above, held an Inspectim (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kamman, Jr. M.D. Medical Examiner.
Date signed 7 Mar. 48

X

G60966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48-04918 159

Registered No. G60966

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital 26-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 hr. 5 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 16 hr. 5 min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore Co.
(c) City or town Baltimore 13,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3331 Dudley Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph John Derrickson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1948

8. AGE: Years	Months	Days	If less than one day
			16 hr. 5 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Frank Derrickson
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Rose Sarah Cangelosi
15. Birthplace Baltimore, Maryland

16 (a) Informant John F. Derrickson
(b) Address 3331 Dudley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director Ellsworth Ringgold
(b) Address 3911 Liberty Heights Ave

19 MAR 8 - 1948 (Date rec'd by registrar) (b) Signature of Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH March 6, 1948, at 3:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 5, 1948, to March 6, 1948, and that I last saw him alive on March 6, 1948.

Immediate cause of death	Duration
Respiratory Failure	
Due to Atelectasis	
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gaetano F. DiPaula M.D.
Address 1400 Caroline St. Date signed 3/6/48

VS 150

EMMA L. McCAULEY

660967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122a

Registered No. 660967

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: University 13-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 51 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 W. 40th St. #11
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emma L. McCawley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Charles O. McCawley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6-1873

8. AGE: Years 74 | Months 9 | Days — | If less than one day hr. min.

9. Birthplace Kent Co. Maryland
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Pearson Jewell
13. Birthplace Maryland

MOTHER
14. Maiden Name Rebecca Haddaway
15. Birthplace Maryland

16 (a) Informant Charles O. McCawley
(b) Address 1208 W. 40th St. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 9-1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) MAR 8 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6 1948, at 10 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1948 to 3/6 1948 and that I last saw her alive on 3/6 1948

Immediate cause of death: Cerebral Embolism Stenocardia
Heart Failure
Due to Arteriosclerosis

Due to

Other Conditions Nitrates.
Total gangrenous toes and feet
(Include pregnancy within 3 months of death)

Date of operation 3/3

Major findings of operation: Gangrene toes -

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. A. Nyhaus M.D.
Address Univ. Hosp Date signed 3/6/48

VS 150

X

G60968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82

G60968

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3511 Copley Rd
(c) Hospital or institution:

15-11

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3511 COPLEY Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLA F. WHITE

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOW

6 (b) Name of husband or wife: FRANK LEE WHITE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/20/1869

8. AGE: Years	Months	Days	If less than one day
79	1	16	hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name JOSEPH A. KING
13. Birthplace ENGLAND

MOTHER
14. Maiden Name MARY E. MacILVANEY
15. Birthplace BALTIMORE, MD.

16 (a) Informant
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/9/48 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE Cem.
Location BALTIMORE, MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTIMORE, MD.

19 (a) MAR 8 1948 (Date rec'd by registrar) Transcription for Williamsburg, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6 1948, at 6:46 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1. 7. 1948 to 3/6 1948 and that I last saw her alive on 3/5 1948.

Immediate cause of death	Duration
Septicemia	14 days
Due to Premature abruption	4 weeks
Due to do not know	
Other Conditions Amyotrophic Lateral Sclerosis	one year

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Maurice E. Shammel
Address 3310 W. North Ave Date signed 3/6/48

VS 150

152

Please write plainly, with INDELIBLE INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G60969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

G60969 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16a
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 434 Poplar Drive St (16)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cecil C Taylor

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	YES

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Joanna Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 28, 1896

8. AGE: Years	Months	Days	If less than one day
52	0	8	hr. min.

9. Birthplace TILGHMAN'S ISLAND, MD.
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business SELF

FATHER
12. Name Dunbar Taylor
13. Birthplace Md.

MOTHER
14. Maiden Name Lola Harrison
15. Birthplace TILGHMANS ISLAND, MD.

16 (a) Informant MR. EDWARD G. TAYLOR (BROTHER)
(b) Address 205 N. CAREY ST.

17 (a) BURIAL (b) Date thereof 3/9/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location BALTIMORE, MD.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address BALTIMORE, MD.

19 (a) MAR 8 - 1948 (b) Notarized for Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-6 1948 at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-25 1948 to 3-6 1948, and that I last saw h alive on 3-6 1948.

Immediate cause of death Coronary thrombosis — Duration

Due to

Due to

Other Conditions Carcinoma left lung.
(Include pregnancy within 3 months of death)

Date of operation 3-5-48

Major findings of operation: Carcinoma left upper lobe of lung

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C B Nourse M. D.
Address Univ. Hosp. Date signed 3-6-48

944

660970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 660970

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp. 27-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6308 Belair Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Henry ROEHNER
3 (b) If veteran, name war None.
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Martha E. Roehner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1872

8. AGE: Years	Months	Days	If less than one day
75	9	15	hr. min.

9. Birthplace Baltimore, Md
(Town, county and state)
10. Usual Occupation RETIRED
11. Industry or business City Health Dept.

MOTHER / FATHER
12. Name UNKNOWN
13. Birthplace "
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mr. David R. Keating (Stepson)
(b) Address 6308 Belair Road
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/8/48 (month) (day) (year)
(c) Cemetery or crematory Loudan Park
Location Baltimore, Md.
18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address Baltimore, Md
19 (a) MAR 8 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 5 1948, at 9:00 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Mar 5 1948 to Mar 5 1948, and that I last saw him alive on Mar 5 1948.

Immediate cause of death	Duration
Cardiorenal failure	
Due to Chronic Nephritis	
Due to	
Other Conditions Diabetes mellitus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Vivian M. B. Duffield
Address St. Joseph's Hosp Date signed 3/5/48

1310

660971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 660971

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1521 E. 33RD ST.
(c) Hospital or institution: 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1521 E. 33RD ST.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Melville E. Harwood

3 (b) If veteran, name war —

3 (c) Social Security Account No. YES

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife GERTRUDE M

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB 8, 1908

8. AGE: Years	Months	Days	If less than one day
40	0	29	hr. min.

9. Birthplace PEMBROKE, CANADA
(Town, county, and state)

10. Usual Occupation ATHLETIC COACH

11. Industry or business ATLANTIC City ICE HOCKEY

FATHER
12. Name GEO. G HARWOOD
13. Birthplace CANADA

MOTHER
14. Maiden Name FLORENCE RYAN
15. Birthplace CANADA

16 (a) Informant MRS. GERTRUDE M. HARWOOD
(b) Address 1521 E. 33RD ST.

17 (a) BURIAL (b) Date thereof 3/10/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory WOODLAWN
Location BALTO. CO., MD.

18 (a) Funeral director WM. T. TICKNER & SONS
(b) Address BALTIMORE MD.

19 (a) MAR 8 - 1948 (b) Huntington Printing Co., Md.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 Mar. 1948 at 10:A.M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Hammer, Jr. M.D.
Medical Examiner.
Date signed 7 Mar. 48

G60972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G60972

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: D.U.A.

(a) Baltimore City, Maryland

(b) Street address 2782 Almeda Blvd

(c) Hospital or institution:

9-7

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore C. Ty

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2782 Almeda Blvd

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Blanche S. Mueller

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Geo. Mueller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUN. 16, 1870

8. AGE: Years	Months	Days	If less than one day
77	8	21	hr. min.

9. Birthplace St. Mary's Co., MD.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Joseph L. Bond

13. Birthplace St. Mary's Co., MD.

MOTHER

14. Maiden Name Mattingly

15. Birthplace St. Mary's Co., MD.

16 (a) Informant Mr. Charles E. Yost

(b) Address 709 Brookwood Rd.

17 (a) Burial (b) Date thereof MAR. 9, 1948

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Balto Co., MD.

18 (a) Funeral director Wm. J. Tickner & Sons

(b) Address Baltimore, MD.

19 (a) MAR 8 - 1948 (b) Registrar

(Date rec'd by registrar)

Remains for Interment

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/7 1948, at 9:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

Signature C. P. Sabrinski M.D.

Medical Examiner.

Date signed 3/9/48

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G60973

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

82

G60973 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 1034
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2203 E. Federal St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Brice James J. Brice

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-01-8653

4. Sex M

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 7th 1910

8. AGE: Years 37 | Months 5 | Days - | If less than one day hr. min.

9. Birthplace Md (Town, county and state)

10. Usual Occupation Sheet Metal Worker

11. Industry or business Yard Locomotive Guard

FATHER
12. Name Wesley J. Brice
13. Birthplace Md

MOTHER
14. Maiden Name Elsie Bennett
15. Birthplace Md

16 (a) Informant Mrs Anna L. Brice
(b) Address 2203 E. Federal St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 11th 1948 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo S. Crook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) MAR 8 - 1948 (Date rec'd by registrar) (b) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1948, at 7:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 7 1948 to March 7 1948 and that I last saw h alive on March 7 1948

Immediate cause of death	Duration
Mesenteric Thrombosis	
Due to Generalized debility & malnutrition	
Due to Injections Neoarsenic - acetarsin, Pneumopyn	
Other Conditions Chronic pyelonephritis, syphilis, uremia & active psoriasis	

Operation (Include operations within 3 months of death)
Date of operation 12-5-47
Major findings of operation: Perforated bladder.
of autopsy: Same as cause

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Geo. Gregory Jr.
Address Univ. Hosp. Date signed 3/7/48 M.D.

VS 139

X

G60974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G60974 Registered No.

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A
(c) Hospital or institution: University Hospital 1502
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 N. Smallwood St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Wolfe

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	widowed

6 (b) Name of husband or wife Eva
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16. (a) Informant Jack Wolfe
(b) Address 1623 N Smallwood St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-9-48 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herring Run

18. (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19. (a) (Date received by registrar) 3-8-1948 (b) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/7 19 48, at 8:50 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature A. S. Lubinski M.D.
Medical Examiner.
Date signed 9/2/48

X

G60975 Herpel

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

73a

G60975 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home + Hospital 6-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Towson Rt. Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 135 N Decker Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mr Michael Otto Herpel (HERPEL)

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-09-2147

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mrs Margaret Herpel

6 (c) If alive, give age 46 ? years

7. Birth date of deceased (mo., day, yr.) Jan 7 1900

8. AGE: Years 48 | Months 1 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Sun Dept Towson Rt

FATHER
12. Name Mr Otto Herpel
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Frederick
15. Birthplace Baltimore Md

16 (a) Informant Mrs Margaret Herpel
(b) Address 135 N Decker Ave Towson Rt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md

18 (a) Funeral director L. Howard Storey
(b) Address 3207 W. North Ave

19 (a) MAR 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1948 at 1000 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 27 1948 to Mar. 4 1948 and that I last saw him alive on Mar. 4 1948.

	Duration
Immediate cause of death Aplastic anemia, acute	6 mos.
Due to	
Due to	
Other Conditions Pernicious anemia	10 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Bachrach M. D.
Address Church Home + Hosp Date signed 3/5/48

VS 150

660976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 660976

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 308 N. Schroeder St

(c) Hospital or institution: 18-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 308 N. Schroeder St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Emma Weldon Gough.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: William Gough.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1890.

8. AGE: Years: 57 | Months: 7 | Days: 8 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Hammond.

13. Birthplace Elliott City, Md..

MOTHER 14. Maiden Name Lizzie Green

15. Birthplace Camp Parole, A.A.G. Md.

16 (a) Informant William Gough.

(b) Address 308 N. Schroeder St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 8 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schrouder St.

19 (a) MAR 8 - 1948 (Date rec'd by Registrar) (b) Registrar

Remarks for William Gough

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1948 at 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1, 1948, to March 4 1948 and that I last saw her alive on March 4 1948.

Immediate cause of death	Duration
Cerebral hemorrhage	1 day
Due to hypertension	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature W. H. Wells M. D.

Address 515 Cathedral St. Date signed 3/5/48

60977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 60977

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 FREDERICK AVE
(c) Hospital or institution:
COLONIAL NURSING HOME 25-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTO.
(c) City or town CHESCO. PK.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 PATAPSCO AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY CATHERINE CAVEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	WIDOWED

6 (b) Name of husband or wife BEAL E. CAVEY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 24 1870

8. AGE: Years	Months	Days	If less than one day
77	9	15	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business OWN HOME

FATHER
12. Name JESSIEL REDMOND
13. Birthplace MARYLAND

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace "

16 (a) Informant JAMES R. C AVEY
(b) Address 522 POPLAR GROVE ST.

17 (a) BURIAL (b) Date thereof 3-9-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory WESTERN CEM
Location EDMONDSON AVE

18 (a) Funeral director Ambrose Jones
(b) Address 414 N. Franklintown Rd.

19 (a) MAR 8 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 March 1948, at 4 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 27 Feb 1948 to 5 March 1948 and that I last saw he alive on 5 March 1948.

Immediate cause of death	Duration
Fracture of Hip	
Due to Cerebral Hemorrhage	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 25/4
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 1-24-48 at ? M
(c) Where did injury occur? 406 Patapsco Ave
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? no
(Specify type of place)
(e) Means of injury slipped + fell to floor

23. Signature Howard J. Wedding M.D.
Address Medical Art Bldg. Date signed 6 March 48

Howard J. Wedding, M.D.

VS 250

G60978

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

G60978 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1322 E. Belvedere Ave
(c) Hospital or institution: 27-15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1322 Belvedere Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cornelia M. Campbell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband: Robert Campbell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 13th 1852

8. AGE: Years 96 | Months 0 | Days 23 | If less than one day hr. min.

9. Birthplace Huntsville, Ala. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

MOTHER / FATHER
12. Name Clack
13. Birthplace Ala.
14. Maiden Name Beard
15. Birthplace Ala.

16 (a) Informant Robert C. Embry
(b) Address 1316 Ramblewood Rd.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/9/48 (month) (day) (year)
(c) ~~Cemetery or crematory~~ Meadow Ridge
Location Dorsey Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St
Date rec'd by Registrar MAR 8 1948 Registrar

VS 152

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 6th 1948, at 9:30 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 28 1948, to Mar 6 1948, and that I last saw her alive on Mar 5 1948.

Immediate cause of death: General senile deterioration due to Marked arteriosclerosis — Duration

Due to

Due to

Other Conditions: Fractured left hip 2 wks ago.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 12-18-47 at 3 M
(c) Where did injury occur? 5511 Yorke Rd. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Fell while getting out of bed

23. Signature Howard J. Masseo, M.D.
Address 1 W. Pleasant Balto. Date signed 3-8-48

Howard J. Masseo, M.D.

C60979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

C60979 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland DOA
(b) Street address 202 W. Chase St
(c) Hospital or institution: — 11-B
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 202 W Chase St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country NATURALIZED CITIZEN

3 (a) FULL NAME Mariah Schunke

3 (b) If veteran, name war —

3 (c) Social Security Account No. 219-18-9347

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	WIDOWED

6 (b) Name of husband or wife ALFRED SCHUNKE
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) JAN. 10, 1871

8. AGE: Years	Months	Days	If less than one day
77	1	26	— hr. — min.

9. Birthplace SOUTH AFRICA (Town, county, and state)
10. Usual Occupation SEAMSTRESS
11. Industry or business FURNITURE

FATHER
12. Name — VOGELZANG
13. Birthplace S. AFRICA

MOTHER
14. Maiden Name —
15. Birthplace S. AFRICA

16 (a) Informant JOHN R. LANGE
(b) Address 3720 W. COLDSPRING LANE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 9, 1948 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location FREDK. AVE.

18 (a) Funeral director Walter Burns Bradley
(b) Address 1922 W. NORTH AVE.

19 (a) MAR 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6 1948, at 6:50 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. P. Culbreth M.D. Medical Examiner.
Date signed 3/6/48

VS 181

X

G60980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G60980 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT ST
(c) Hospital or institution: MERCY HOSP 8 W 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 D.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE, MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2127 E. CHASE ST.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES J. STRICKER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife RUTH STRICKER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation DISPATCHER - BALTI-TRANSIT
11. Industry or business

FATHER
12. Name FRANK STRICKER
13. Birthplace AUSTRIA

MOTHER
14. Maiden Name ANNE ?
15. Birthplace AUSTRIA

16 (a) Informant ADM. SLIP
(b) Address

17 (a) Burial (b) Date thereof 3-10-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto Md

18 (a) Funeral director Frank Lynch & Son
(b) Address 900 N. Chester Ave. 5

MAR 8 - 1948
(Date rec'd by registrar) Interring for Williams Mill

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 6 1948 at 7.55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/24 1948 to 3/6 1948 and that I last saw h[illegible] alive on 3/6 1948

Immediate cause of death CARDIO-RESP FAILURE — Duration

Due to CORONARY THROMBOSIS

Due to PULMONARY INFARCTION

Other Conditions CORONARY SCLEROSIS

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy MYOCARDIAL INFARCTION PULMONARY INFARCTION

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elden H. [illegible]
Address Mercy Hosp Date signed 3/6/48

VS 150

660981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 660981

GH. 114657 V13B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospit ls. 3-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 4 Months
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 409 S. Caroline ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Raymond Alexander Wright

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Grace

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23 - 1891

8. AGE: Years	Months	Days	If less than one day
56	4	11	hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Wright
13. Birthplace MD.

MOTHER
14. Maiden Name Laura Happon
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospital
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 9-1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1011 Baltimore ave

19 MD 8-1948 Date rec'd by registrar Betty for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 3 - 1948, at 11.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10 - 21 1947 to 3 - 3 - 1948, and that I last saw him alive on 3 - 3 - 1948

Immediate cause of death Bilateral Far. advanced fibro-caseous Pulmonary Tuberculosis — Duration ?

Due to With Cavitation and dissemination to epicardium, kidneys and Mesenteric lymph nodes

Due to

Other Conditions Ascites Malnutrition

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Same

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laurence Lee Jr. M. D.
Address Baltimore City Hosp Date signed 3-4-48

VS 150

C60982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. C60982

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore MD
(If outside city or town limits, write RURAL and give town)
(d) Street No. 150 McKean Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country PINE

3 (a) FULL NAME Geraldine Floyd

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Negro	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/15/1923

8. AGE: Years	Months	Days	If less than one day
25	1	18	hr. min.

9. Birthplace Baltimore, MD
(Town, county, and state)
10. Usual Occupation Laundress
11. Industry or business

FATHER
12. Name John Cooper
13. Birthplace Va.

MOTHER
14. Maiden Name Laura Boyer
15. Birthplace md

16 (a) Informant John Cooper
(b) Address 1120 McKean Ave

17 (a) Burial (b) Date thereof 3/13/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Frederick Ave

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 927 N. Mount St.

19 (a) MAR 8 - 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/7/48, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/5/48 1948, to 3/7 1948, and that I last saw h[illegible] alive on 3/7 1948

Immediate cause of death: Rheumatic Heart Disease — Duration 4 yrs
Due to
Due to
Other Conditions Lumbar Abscess
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William Dames
Address 45 Division St Date signed 3/8/48

VS 190

660983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 660983

660983

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 238 S Monastery Ave

(c) Hospital or institution St Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)

(d) Street No. 238 S. Monastery Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME John H. Jonske

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-10-8811.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Kate Jonske.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 5-1879

8. AGE: Years 69 | Months 2 | Days 0 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Furniture Polisher.

MOTHER | FATHER

12. Name Albert Jonske (dead)

13. Birthplace Germany

14. Maiden Name Johanna Trendler

15. Birthplace Germany (dead)

16 (a) Informant Mrs. George T. Ottenheit.

(b) Address 338 S. Monastery Ave.

17 (a) Burial, (Burial, cremation, or removal) (b) Date thereof March 9-48 (months) (day) (year)

(c) Cemetery or crematory Loudon Park Cem. Location City.

18 (a) Funeral director Charles J. Schwab.

(b) Address 3512 Frederick Ave.

19 (a) MAR 8 - 1948 (Date rec'd by Registrar) (b) Signature of Registrar Livingston Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 Mar 1948, at 6:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1 Mar 1948 to 5 Mar 1948. and that I last saw him alive on 5 Mar 1948

Immediate cause of death Left Heart Failure.

Due to Hypertensive C.V. Disease

Due to Fracture Hip left.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 20/8

(a) Accident, suicide, or homicide? Home Accident

(b) Date of occurrence 1 Mar 48 at 900 A.M.

(c) Where did injury occur? 5217 Fairmount Ave (City or town) Baltimore (County) Md. (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No

(e) Means of injury Fall down steps at home

23. Signature J. H. Smith M.D. M. D.

Address St Agnes Hosp. Date signed Mar 8 48

For Dr. E. J. Schmidt, Medical Examiner

G60984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G60984

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St

(c) Hospital or institution: South Balto Gen Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hours

(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1709 N. Port Street (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Charles D. Hare

3 (b) If veteran, name war None

3 (c) Social Security Account No. 717-07-6907

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Catherine

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) June 17, 1879.

8. AGE: Years 68 Months 8 Days 15 If less than one day 16 hr. min.

9. Birthplace Mary Canal (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Coca Cola Company

FATHER 12. Name Charles H. Hare

13. Birthplace Maryland

MOTHER 14. Maiden Name Frances Lovett

15. Birthplace Maryland

16 (a) Informant Mrs. Mary C. Hare

(b) Address 1709 N. Port St. Balto. 13, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 9, 1948 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery

Location Baltimore, Maryland

18 (a) Funeral director Eaton & Sons

(b) Address Ellicott City, Maryland

19 (a) MAR 8 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1948, at 10:58 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 5 1948 to March 5 1948, and that I last saw him alive on March 5 1948.

Immediate cause of death: Myocardial infarction — Duration 4 hrs.

Due to: coronary occlusion — 4 hrs.

Due to: Hypertensive arterio-sclerotic heart disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Harold A. Dillon

Address South Balto Gen Hosp Date signed Mar 5 M. D.

VS 150

X

60985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 60985

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 520 East 27th, Street

(c) Hospital or institution: 9-

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 520 East 27th Street (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LAWRENCE S. BRUNS, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary T.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, (1880) 1879

8. AGE: Years	Months	Days	If less than one day
68	8	8	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Lawrence A. Bruns

13. Birthplace Maryland

MOTHER 14. Maiden Name Agnes (Gasney) Kerney

15. Birthplace Virginia

16 (a) Informant Miss Ann Bruns

(b) Address 520 East 27th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/10/48 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location City

18 (a) Funeral director WIEDEFELD & SON

(b) GREENMOUNT AVE & 22ND

19 (a) MAR 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6/48 19..., at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to March 6 1948 and that I last saw h[illegible] alive on Dec 1947

Immediate cause of death Cerebral hemorrhage

Due to Hemiplegia, arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
?
?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Salvatore J. Guazzano M. D.

Address 2802 Harford Rd Date signed 3/8/48

V S 150

G60986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

Registered No. G60986

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 336 East 27th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 336 East 27th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCIS PHILBIN SCHAECHER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elaine P.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years	Months	Days	If less than one day
37			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Filling Station Operator
11. Industry or business

FATHER
12. Name Christian H. Schaecher
13. Birthplace Balto.,

MOTHER
14. Maiden Name Ella Philbin
15. Birthplace Balto.

16 (a) Informant Mrs. F.P.Schaecher
(b) Address 648 S. Payson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/10/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREENMOUNT AVE & 22ND

19 (a) Mar 8 1948 (b) Kathryn Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6/48 1948, at 8.10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10, 1948, to March 6, 1948, and that I last saw him alive on March 6, 1948.

Immediate cause of death	Duration
Myocardial Failure	2 months
Due to Chronic Endocarditis	Unknown
Due to Chronic Myocarditis	"
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ~
(b) Date of occurrence ~ at ~ M
(c) Where did injury occur? ~ (City or town) ~ (County) ~ (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ~ (Specify type of place) While at work? ~
(e) Means of injury ~

23. Signature Francis M. Opdyke M. D.
Address 2701 N. Calvert St. Date signed March 7, 48.

V S 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

660987 660987

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4301 ROLAND AVE.
(c) Hospital or institution: KIRKLEIGH VILLA.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 YEARS 27-14
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4301 ROLAND AVE (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME: MARY AGNES KENNEY.

3 (b) If veteran, name war: -----

3 (c) Social Security Account No. -----

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1857

8. AGE: Years 90 | Months 9 | Days 28 | If less than one day: hr. min.

9. Birthplace County Clare, Ireland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Matthew Kenney
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Conroy
15. Birthplace Ireland

16 (a) Informant Sister Mary Germaine
(b) Address Kirkleigh Villa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans Sons Inc.
(b) Address 118 N. Pitt Street

19 (a) MAR 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 7 1948 19 , at 1.P. M

21. I certify that death occurred on the date above stated; that I attended deceased from JANY 26 19 48 to MARCH 7 19 48 and that I last saw her alive on MARCH 7 19 48

Immediate cause of death	Duration
CHRONIC MYOCARDITIS JANUARY	26.1948
Due to	
ARTERIOR SCLEROSIS	1948
Due to	
Other Conditions	
SENILITY.	

(Include pregnancy within 3 months of death)

Date of operation NONE
Major findings of operation: NONE
of autopsy: NONE

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. J. Schmeltzer
3013 ST PAUL STREET. MARCH 7 1948
Address Date signed

VS 190

660988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓830

Registered No. 660988

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4103 Newton Ave.,
(c) Hospital or institution: 28
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4103 Newton Ave., (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cyrus Edward Bowerson

3 (b) If veteran, name war: --

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Louisa C. Bowersox

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1867

8. AGE: Years 80 | Months 11 | Days 23 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

MOTHER | FATHER

12. Name Hezekiah Bowersox

13. Birthplace Md.

14. Maiden Name May Fliekinger

15. Birthplace Md.

16 (a) Informant Mrs. Lillian Faherty

(b) Address 4103 Newton Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-9-48 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park

Location Woodlawn, Md.

18 (a) Funeral director G. Howard Strong

(b) Address 3207 W. North Ave.

19 (a) MAR 8 - 1948 (Date rec'd by registrar) (b) Transferred from Williamsport, Md. Registrar

VS 150

MEDICAL CERTIFICATION 4.00

20. DATE OF DEATH March 6, 1948, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2 1945 to March 6 1948, and that I last saw him alive on March 6 1948

Immediate cause of death CEREBRAL HEMORRHAGE — Duration 2 Days

Due to CEREBRAL ARTERIOSCLEROSIS — 8 YEARS

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Manuel Levin

Address 4818 Reisterstown Rd. Date signed March 8/48 M. D.

C60989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C60989

1 37a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Carroll
(c) City or town Rural - Mount Airy (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Frank Buxton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1875

8. AGE: Years	Months	Days	If less than one day
72	5		hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Telegraph Operator
11. Industry or business P & O R.R.

FATHER
12. Name Brooke Buxton
13. Birthplace Md

MOTHER
14. Maiden Name Emma Spencer
15. Birthplace Md

16 (a) Informant Walter Spencer
(b) Address Mt Airy Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 10 1948 (month) (day) (year)
(c) Cemetery or crematory Prospect Cem
Location Mt Airy

18 (a) Funeral director Hoffy Ware
(b) Address Sykesville Md

19 (a) MAR 8 - 1948 (Date rec'd by registrar) (b) Courtenay Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. **DATE OF DEATH** March 8 1948, at 1 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1948 to March 8 1948, and that I last saw him alive on March 7 1948.

Immediate cause of death	Duration
Uremia	
Due to Enlarged Kidneys	
Due to Prostatic obstruction	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: B.P.H.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. **Signature** John Benson M.D.
Address Gen. Hospital Date signed 3/8/48

VS 153

X

G60990

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 939

G60990
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7211 W. ROGERS AVE
(c) Hospital or institution Home for the Aged of the Meth Church
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7211 W. ROGERS AVE
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME J. ANNA Royston

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: WIDOWED
6 (b) Name of husband or wife: CAMPBELL B.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) FEB. 9, 1872

8. AGE: Years 76 | Months 0 | Days 29 | If less than one day: hr. min.

9. Birthplace PORT DEPOSIT, MD.
(Town, county, and state)

10. Usual Occupation HOUSEWIFE
11. Industry or business —

FATHER
12. Name FRANCIS S. EVERIST
13. Birthplace DELNA

MOTHER
14. Maiden Name SARAH KERR
15. Birthplace KERR'S ISLAND - PORT DEPOSIT, MD.

16 (a) Informant KATHERINE WIMMER
(b) Address 7211 W. ROGERS AVE

17 (a) BURIAL (b) Date thereof 3/9/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory GREENMOUNT CEM.
Location BALTIMORE, MD.

18 (a) Funeral director WM. J. TIZZER & SONS
(b) Address BALTIMORE, MD.

19 (a) MAR 8 1948 (Date received by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 8 1948, at 6 20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 17 1948 to Mar 8 1948 and that I last saw had alive on Mar 5 1948.

	Duration
Immediate cause of death: Pulmonary Edema,	
Due to: Cardio Vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
If autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles D Warner M.D.
Address 421 - Med. Arts Bldg. Date signed 3/8/48

VS 150

C60991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C60991

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.A.
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 620 S. Broad St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Metra Bielawski

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Unknown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Unknown (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 4 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAR 8 - 1948 (Date rec'd by registrar) (b) Huntington Woollcombe, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/27 1948, at 9:25 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V disease

Due to

Other Conditions Pneumonia Left Lobe

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature G. K. Fabricius M.D.
Medical Examiner.
Date signed 2/27/48

VS 181

G60992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 107

G60992 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1315 N. Charles St.
(c) Hospital or institution:
(D.O.A. Mercy Hospital) 11-07
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 N Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Burnell ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 23. 1892

8. AGE: Years	Months	Days	If less than one day
56	1	14	hr. min.

9. Birthplace Pa
(Town, county, and state)

10. Usual Occupation
11. Industry of business

FATHER 12. Name James Burnell
13. Birthplace Pa.

MOTHER 14. Maiden Name Seneca Bennett
15. Birthplace Pa

16 (a) Informant Jonas Fritz
(b) Address Lewistown Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/48 (month, day) (year)
(c) Cemetery or crematory Lewistown
Location Lewistown Pa

18 (a) Funeral director Pittenger & Fry
(b) Address 1219 Park Ave

19 (a) MAR 8 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VB 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7, 1948, at 2:25 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Broncho pneumonia
Bronchiectasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 7 at 48 2:25 P.M.
(b) Where did injury occur? 1315 N. Charles St.
(c) Did injury occur at home, on farm, industrial place, in public place? Residence While at work? No
(d) Means of injury Natural Causes

23. Signature [signature] M.D.
Medical Examiner
Date signed March 8/48

G60993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161

Registered No. G60993

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Doctor's 2724 N. Charles 9-07 street
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1532 Homestead (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCIS L. REISLER

3 (b) If veteran, name war: no
3 (c) Social Security Account No. ---

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: ---
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1895

8. AGE: Years 52 | Months 5 | Days 14 | If less than one day ___ hr. ___ min.

9. Birthplace Carroll Co. Maryland (Town, county, and state)
10. Usual Occupation Lithograph Type Finisher
11. Industry or business

FATHER
12. Name Murray Reisler
13. Birthplace Carroll Co., Md.

MOTHER
14. Maiden Name Cecelia I. Utz
15. Birthplace Maryland

16 (a) Informant Mr. Stanley Reisler
(b) Address 2776 Alameda Boulevard

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director Chas J. Evans Son Inc
(b) Address 118 W. Mt. Royal Ave

19 Mar 9 1948 (Registered by Registrar) (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1947 to March 6 1948 and that I last saw h[illegible] alive on March 6 1948.

Immediate cause of death	Duration
Respiratory Failure	
Due to Cerebral Hemorrhage	
Due to Hypertension	
Other Conditions Diabetes, Generalized Arteriosclerosis.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leaciel K. Freelenty M. D.
Address 2116 W. Pratt St. Date signed 3/8/48

VS 150

834

660994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 13B

660994 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3711 Brooklyn Ave
(c) Hospital or institution: 2504

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3711 Brooklyn Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth M. Phelps

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Curtis Phelps
6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) July 30, 1919

8. AGE: Years	Months	Days	If less than one day
28	7	17	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Louis Bayer
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Parent
15. Birthplace Md

16 (a) Informant Mr Curtis Phelps
16 (b) Address 3711 Brooklyn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/48 (month) (day) (year)
17 (c) Cemetery or crematory Glen Haven
Location Annapolis Blvd

18 (a) Funeral director John F. Denny Sue
18 (b) Address 715 Eight St.

19 (a) MAR 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1948 at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to Mar 4 1948, and that I last saw her alive on Mar 4 1948.

Immediate cause of death	Duration
Intracerebral hemorrhage generalized	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Shirley W. Lewter, MD M. D.
Address 302 Patapsco Ave Date signed Mar 8 '48

VS 130

C60995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 512

Registered No. C60995

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No. 172 Penna. Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert L. Mobley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Daisy Mae

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) 10/4/75

8. AGE: Years 72 | Months 5 | Days 4 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

MOTHER / FATHER

12. Name Leander Mobley

13. Birthplace Md

14. Maiden Name Elizabeth Lookingbill

15. Birthplace Md

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/48 (month) (day) (year)

(c) Cemetery or crematory Westminster

Location Carroll Co

18 (a) Funeral director J S Bankard & Son

(b) Address Westminster Md

19 MAR 9 - 1948 (Date rec'd by registrar) Washington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-8- 1948, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-5- 1948 to 3-8- 1948 and that I last saw h[illegible] alive on 3-5- 1948

Immediate cause of death: Coronary occlusion — Duration

Due to

Due to

Other Conditions Arteriosclerosis Nephritis - Carcinoma prostate

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard C. Clay M. D.

Address Johns Hopkins Hosp Baltimore, Md 94a Date signed 3-10-48

660996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. 660996

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 605 N. Entaw Ave
(c) Hospital or institution: 5-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 605 N. Central ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hebert French

3 (b) If veteran, name war NO

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Elizabeth French 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years 45 | Months | Days | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Paper Hanger

11. Industry or business

FATHER 12. Name William French

13. Birthplace Balto Md

MOTHER 14. Maiden Name Isabella Gross

15. Birthplace Balto Md

16 (a) Informant William French Bolton

(b) Address 601 N Central Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 9-1948 (month) (day) (year)

(c) Cemetery or crematory Mt Cal Cem

Location Brooklyn Md

18 (a) Funeral director Chas. O. Wilson

(b) Address 1000 Brantly ave

19 (a) MAR 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-5 1948, at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-28 1948, to 3-5, 1948, and that I last saw him alive on 1948

Immediate cause of death Acute Respiratory failure, Duration

Due to lobar pneumonia 1 wk

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. C. Burwell

Address 1711 Aisquith St Date signed 3-9-48 M.D.

V S 150

660997

BALTIMORE CITY HEALTH DEPARTMENT

Artish CERTIFICATE OF DEATH 937

Registered No. 660997

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1402 E. Fairmount Ave
(c) Hospital or institution: 5-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1402 E. Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lee Artish

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Mle	col	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Cement Finisher
11. Industry or business

FATHER
12. Name not known
13. Birthplace not known

MOTHER
14. Maiden Name not known
15. Birthplace not known

16 (a) Informant Lois Holmes
(b) Address 1402 E. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 9, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemt
Location Baltimore Md

18 (a) Funeral director Edward O. Wilson
(b) Address 1605 Bentley Ave

19 (a) MAR 9 - 1948 (Date rec'd by registrar) Huntington Williams (Registrar)

3-6-48 **MEDICAL CERTIFICATION**

20. DATE OF DEATH 3-6-48 at 11.11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 1948 to 3-6 1948 and that I last saw him alive on 3-4 1948.

Immediate cause of death	Duration
Circulatory failure	
Due to Coronary Insufficiency	Unknown
Due to Hypertension & Myocardial degeneration	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Trowbridge M.D.
Address 1623 E. N. Ave Date signed 3/8/48

V S 150

X

660998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 660998

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400-04 W. Lexington St.

(c) Hospital or institution: Aged Women's & Men's Homes 19 0 V

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 1400 W. Lexington St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice M. Nelson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: William K. Nelson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/18/1862

8. AGE: Years 85 | Months 7 | Days 19 | If less than one day hr. min.

9. Birthplace Crownsville Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business House for the Aged

FATHER

12. Name Thomas C. Brown

13. Birthplace A. A. Co. Md.

MOTHER

14. Maiden Name Margeret C. Miller

15. Birthplace Crownsville Md.

16 (a) Informant (Mrs.) L. H. Read Supt.

(b) Address 1400-04 W. Lexington ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/48 (month) (day) (year)

(c) Cemetery or crematory St. Pauls

Location Crownsville Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

19 (a) MAR 9 - 1948 (Date rec'd by registrar) Investigator for Williams, M.E.

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 7 1948, at 8.00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1st 1947, to March 6 1948, and that I last saw h.. alive on March 6 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Generalized arteriosclerosis	
Due to	
Other Conditions Hypertensive Vascular disease (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Vernland Edward Day M. D.

Address 4-E-33rd St Balto Md Date signed 3/8/48

V S 150

G60999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 192 B

Registered No. G60999

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 119 S. Stockton
(c) Hospital or institution: 18.03
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 119 S. Stockton (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sadie Frederick Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden Name Elizabeth —

15. Birthplace Va

16 (a) Informant Helen Goodwin

(b) Address 1136 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-9-48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Balto. Md.

18 (a) Funeral director James A. Stafford

(b) Address 142 W. Fayette St

19 (MAR 9 - 1948) (b) Huntington Nottingham, Md. Registrar

(When rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1948, at 3.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-3-48 19 to 3-6-48 19, and that I last saw h alive on 19

Immediate cause of death Cerebral Insufficiency — Duration 4 days

Due to

Due to Cardiac Hypertension — Duration 3 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Cardozo M. D.

Address 524 Park Ave Date signed

V S 150

G61000 G9c220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

104a

Registered No. G61000

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 909 N. Stricker St.
(c) Hospital or institution: 16-0
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 909 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Edison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/11/47

8. AGE: Years	Months	Days	If less than one day
	2 mo	27	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William H. Edison
13. Birthplace Greenville, N.C.

MOTHER
14. Maiden Name Bertha Lauderdale
15. Birthplace Wainsboro S.C.

16 (a) Informant William H. Edison
(b) Address 909 Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 9 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winder

18 (a) Funeral director Charles H. Alexander
(b) Address 1200 McCulloh St. Baltimore

19 (a) MAR 9 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1948, at 1 M

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑; accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Upper respiratory infection

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.

Date signed 3/8/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 191

661001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 661001

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2808 Huntingdon Ave.
(c) Hospital or institution: 1907

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2808 Huntingdon Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida M. Wisner.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife George B. Wisner.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28 1871

8. AGE: Years	Months	Days	If less than one day
76	9	16	hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Housewife.
11. Industry or business ?

MOTHER / FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Clayton B. Wisner.
(b) Address 2808 Huntingdon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 10 1948 (month) (day) (year)
(c) Cemetery or crematory Maryland Park.
Location Taylor Ave.

18 (a) Funeral director Chas E Whitehurst & Son
(b) Address 3615-17 Chestnut Ave.

19 (a) (Date received by Registrar) (b) Huntington Williams, Md.

MAR 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 8, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1948 to Mar 8, 1948 and that I last saw h.y alive on Mar 7, 1948.

Immediate cause of death	Duration
Cerebral Haemorrhage	2 days
Due to Hypertensive C.V. Dis.	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin H. Harriman M.D.
Address 4077 Falls Rd Date signed 3/8/48

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

061002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 061002

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LOMBARD AND GREENE STS.
(c) Hospital or institution: UNIVERSITY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County ANNE ARUNDEL
(c) City or town ANNAPOLIS (If outside city or town limits, write RURAL and give town)
(d) Street No. 126 PRINCE GEORGE ST. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME NEDRA CARVILLE
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F. ~~M.~~ | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife FRANK
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-21-1915

8. AGE: Years 32 | Months 5 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER
12. Name Oliver Howard
13. Birthplace Md.

MOTHER
14. Maiden Name Cora Locket
15. Birthplace Md.

16 (a) Informant Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-12-48. (month) (day) (year)
(c) Cemetery or crematory St. Anne's
Location Annapolis, Md.

18 (a) Funeral director C. L. Hopkins & Son
(b) Address 172-172 West St. Annapolis, Md.

19 MAR 9 - 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 8 1948, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-6 1948 to 3-8 1948. and that I last saw her alive on 3-8 1948.

Immediate cause of death	Duration
Gastric Hemorrhage	
Due to Esophageal Varices	
Due to Cirrhosis of Liver	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ~~Accident~~
(b) Date of occurrence ~~3-6-48~~ at ~~3 P.M.~~
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ~~Home~~ (Specify type of place) While at work?
(e) Means of injury ~~Burns & Scalds~~

23. Signature J. B. Workman M. D.
Address Univ. Hosp. Date signed 3-8-48

124B

vs 8a

661003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

661003 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 S. Carey Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose B. Bolger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John Bolger
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 9/13/11

8. AGE: Years	Months	Days	If less than one day
36 37	5	14 24	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Louis Koellner
13. Birthplace Germany

MOTHER
14. Maiden Name Martha Frank
15. Birthplace Germany

16 (a) Informant Mrs Frieda Dailey
(b) Address 1222 S Carey ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MARCH 11 1948 (month) (day) (year)
(c) Cemetery or crematory WESTERN
Location EDMONDSON AVE - LONGWOOD STS

18 (a) Funeral director Harry A Witzke
(b) Address 4101 Edmondson Ave

19 (a) MAR 9 - 1948 (Date filed by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1948, at 6 00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 1948 to Mch. 7 1948, and that I last saw her alive on March 7 1948.

	Duration
Immediate cause of death Metastatic Carcinoma	3 mos.
Due to Adenocarcinoma of rectum	9 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1-23-48
Major findings of operations Metastases.
of autopsy: Consent.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles B. MacDonell
Address 1213 Light St. Date signed 3-8-48

VS 150

G61004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No. G61004

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Baltimore Ferndale
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Frank Cole

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-1470

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1878

8. AGE: Years 70 | Months 2 | Days 1 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Warehouse Man

11. Industry or business American Stores

FATHER
12. Name James R. Cole
13. Birthplace Va.

MOTHER
14. Maiden Name Mellisa Patterson
15. Birthplace Va.

16 (a) Informant Mrs. Isabelle Goodman
(b) Address Ferndale, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave. & Longwood St.

18 (a) Funeral director Henry A. Wittstein
(b) Address 4101 Edmondson Ave.

19 (a) (Date rec'd by Registrar) (b) Registrar

MAR 9 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/5 1948, at 2:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/21 1948, to 3/5 1948, and that I last saw him alive on 3/5 1948.

Immediate cause of death Respiratory Failure — Duration

Due to Bilateral Lobar Pneumonia

Due to

Other Conditions Bleeding when in Rectum

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Left Hypernephroma metastasis to Brain

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James E Hamill M.D.
M. D.
Address St Agnes Hosp Date signed 5 Mar 48

108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information must be answered correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G61005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G61005

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3020 Iona Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lee W. Fowler

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-03-4901

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bertha C. Fowler

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Jan. 8 1881

8. AGE: Years	Months	Days	If less than one day
67	1	28	hr. min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual Occupation Accountant

11. Industry or business B & O R.R.

FATHER
12. Name Charles Fowler
13. Birthplace Ohio

MOTHER
14. Maiden Name Rebecca Reynolds
15. Birthplace Ohio

16 (a) Informant Mrs Bertha C. Fowler
(b) Address 3020 Iona Terrace

17 (a) Burial (b) Date thereof 3/9/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Parkville Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 E. Paul St.

19 MAR 9- 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1948, at 3:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-0 19- to 3/6 - 1948
and that I last saw h alive on 19

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank G. Fraunfelter for P. H. Davis by X Howard J. Madden, M.D.

Address Lutherville Md. Date signed 3/8/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be complete and correct as far as practicable. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

VS 150

461006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 461006

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 19-0 W
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cecilia Petticord (or) Paddicord

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

MOTHER - FATHER
12. Name Joseph Gumbert
13. Birthplace Germany
14. Maiden Name Barbara Ehrsberger
15. Birthplace Germany

16 (a) Informant Frank J. Gumbert
(b) Address 2210 Ceicel Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 9 48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd

18 (a) Funeral director Dippel Bros
(b) Address 1800 E Lombard St.

19 (a) MAD 9 (Date received by registrar) (b) Wellington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-7-1948 at 8:30 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy / Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil Rogers M.D. (Medical Examiner)
Date signed 3-8-48

VS 191

66.1007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. 66.1007

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given or correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2110 N. Howard St.
(c) Hospital or institution: 14-03
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 531 Roberts St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Chase

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
World War II	212-22-8511	M	C	Married

6 (b) Name of husband or wife Virginia Chase
6 (c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.) 3/24/27

8. AGE: Years	Months	Days	If less than one day
20 ?	11	13	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name William D. Chase
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Regnis Taylor
15. Birthplace Wash. D. C.

16. (a) Informant Mrs Regnis Chase
(b) Address 531 Robert St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/10/48 (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem.
Location Balto. Md.

18 (a) Funeral director William O. Chatman Jr.
(b) Address 1201 McCulloh St.

19 (a) MAR 9 1948 (Date rec'd by registrar) (b) Everington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1948, at 10:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bullet wound of abdomen.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 1 1948 M.
(b) Where did injury occur? 2110 N. Howard St.
(c) Did injury occur at home, on farm, industrial place, in public place? Social Hall While at work? No.
(d) Means of injury Firearm

23. Signature [signature] M.D. Medical Examiner.
Date signed 3-9-48

VS 181

X

G61008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 457

Registered No. G61008

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Johns Hopkins 10-07

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1236 Ashland (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RODGERS JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace ? Virginia (Town, county, and state)

10. Usual Occupation Gardner

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace ?

MOTHER
14. Maiden Name Unknown
15. Birthplace ?

16 (a) Informant Mrs. Blanches Watts
(b) Address 1522 Ashland Ave.

17 (a) Burial (b) Date thereof 3-9-48 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1402 E Preston St.

19 MAR 9 - 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/7/48 19 , at 1.30 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma Mandible

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 3/8/48

VS 151

G61009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G61009

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1615 N. Dallas St.

(c) Hospital or institution: 8-06

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1615 N. Dallas St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Luther Kirby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lavenia Kirby

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22, 1902

8. AGE: Years 46 | Months 10 | Days 14 | If less than one day hr. min.

45

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER

12. Name Martin Kirby

13. Birthplace Md.

MOTHER

14. Maiden Name Unknown

15. Birthplace Md.

16 (a) Informant Lavenia Kirby

(b) Address 1615 N. Dallas St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-9-48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A. G. Co

18 (a) Funeral director Rayner Sanders

(b) Address 1412 E. Preston St.

19 (a) MAR 9 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6th 1948 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 4th 1948 to March 6th 1948. and that I last saw h[illegible] alive on March 4th 1948.

	Duration
Immediate cause of death Coronary Thrombosis	
Due to Hypertension & Chronic Myodegeneration of the Heart	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Hart Traynor M.D.

Address 1623 E. N. Ave. Date signed 3/8/48

VS 150

061010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 061010

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Ln.
(c) Hospital or institution: Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-01
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County:
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Egidio Molinari

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	M.

6 (b) Name of husband or wife Thomas —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1863

8. AGE: Years	Months	Days	If less than one day
85	1	15	hr. min.

9. Birthplace Italy (town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Pietro Molinari

13. Birthplace

MOTHER 14. Maiden Name Jacopini Batiste

15. Birthplace

16 (a) Informant Sister Sister Superior

(b) Address 1200 Valley Ln.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 10, 1948 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Rita Wiedefeld

(b) Address 900 East Biddle St

19 (a) MAR 9 — 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1948, at 10:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 — 1948, to Mch 6 — 1948, and that I last saw h. alive on Mch 6 — 1948.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to	
Due to Chronic Myocarditis	5 yr
Other Conditions Arterio-Sclerosis	10 yr

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall

Address 1631 E. North Ave. Date signed 3/8/48 M. D.

VS 150

G61011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 108

G61011

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 716 E. 21st. Street

(c) Hospital or institution: 5-0 ✓

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. ~~716 E. 21st. St.~~ 409 Colvin St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John J. Stevenson

3 (b) If veteran, name war: Spanish American

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife: Julia V. Stevenson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1873

8. AGE: Years	Months	Days	If less than one day: hr.	min.
74	9	16		

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Ry. R.R.

11. Industry or business Retired Clerk

FATHER

12. Name Wm. Stevenson

13. Birthplace Baltimore

MOTHER

14. Maiden Name Margaret Mallon

15. Birthplace Ireland

16 (a) Informant Miss Stevenson

(b) Address 409 Colvin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 11, 1948 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Rita Weidefeld

(b) Address 900 E. Biddle St.

19 (a) MAR 9 - 1948 (Date rec'd by regis. dist.) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1935, to March 8 1948, and that I last saw alive on March 8 1948

Immediate cause of death: Congestive failure (left & right side) - Pulm. edema — Duration: 6 days

Due to: Pneumonia (Intermediate) — 2 weeks

Due to: Cardio Vascular disease — ?

Other Conditions: — over

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Samuel Silverfield M. D.

Address 714 E. Preston 2 Date signed May 9, 1948

X

G61012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

87

Registered No. G61012

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 7yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore DUNDALK
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 East Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas William Achey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1929

8. AGE: Years	Months	Days	If less than one day
18	9	17	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Elmer Edgar Achey
13. Birthplace Penna

MOTHER
14. Maiden Name Kirk Yeager
15. Birthplace Penna

16 (a) Informant Mrs. Elmer E. Achey
(b) Address 1813 East Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location O'Donnell Str Rd

18 (a) Funeral director John B Connelly
(b) Address 414 Eastern Ave

19 (a) MAR 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5, 1948 at 12:25 M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/25 1948 to 3/5 1948, and that I last saw him alive on 3/5 1948.

Immediate cause of death	Duration
Cardio Respiratory Failure	
Due to Lobular pneumonitis	
Due to Cerebral Edema	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Cerebral Edema & Pulmonary

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wallace A. Bailey M. D.
Address 1400 Caroline Date signed 3/5/48

VS 150

107

661013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. 661013

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Provident Hosp.
(c) Hospital or institution: 14 ward
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 Etting St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard A. Wright.

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-7003

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Ellen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1890

8. AGE: Years 57 | Months 3 | Days 13 | If less than one day hr. min.

9. Birthplace Nash, D. C. (Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER 12. Name Isaac Wright

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden Name Lucy Carter

MOTHER 15. Birthplace Westmoreland Co. Va.

16 (a) Informant: Victor Wright

(b) Address 1629 Druid Hill Ave none

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-9-1948 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Park

Location Baltimore Co. Md.

18 (a) Funeral director Chas. Sumner H. Stallard

(b) Address 1631 Druid Hill Ave

19 (a) Filed by Registrar 3-10-1948 (b) Thurlington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-6-1948 at 2.17 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-2-1948 to 3-6-1948 and that I last saw h. alive on 3-6-1948.

Immediate cause of death: Carcinoma Head of Pancreas.

Due to:

Due to:

Other Conditions: Partial High intestinal Obstruction due to Ca.

(Include pregnancy within 3 months of death)

Date of operation 2-25-48

Major findings of operation: Ca. appeared Ca. of Pancreas invasion of Stomach at Duodenum and C. bile duct

Duration
4 wks.

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ann Robinson

Address Provident Hosp. Date signed 3-8-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G61014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G61014

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Use "None" or "Unknown" where necessary. Physicians: please write the causes of death clearly and legibly. Be sure that the age is correctly stated. Do not abbreviate. Use ditto marks only when they will not be misunderstood. Do not write in the space marked "Registrar."

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Glyndon (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Stephen Duvall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 4 1871

8. AGE: Years	Months	Days	If less than one day
76	7	5	hr. min.

9. Birthplace Laurel, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Charles S. Duvall
13. Birthplace Md

MOTHER
14. Maiden Name Mary Amelia Baldwin
15. Birthplace Md

16 (a) Informant Jessie Dem
(b) Address Glyndon, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 11-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Nat'l Cem.
Location Balto., Md.

18 (a) Funeral director J. F. Linn & Sons
(b) Address Reisterstown Md.

19 (a) MAR 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1948, at 5 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Fracture of skull
Intracranial hemorrhage

Due to

Other Conditions Fract. ribs; Fract. left tibia, fibula; Generalized abscess
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-6-48 at 2:45 P.M. (Battle Axe)
(b) Where did injury occur? Main St. - Reisterstown, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No Connection
(d) Means of injury Pedestrian struck by auto

23. Signature [signature] M.D. Medical Examiner.
Date signed 3-9-48

61015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 61015

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Use "None" or "Unknown" where correct answer is not known. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 301
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 E. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
51			hr. min.

9. Birthplace Woodbury Penna. (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace " "

MOTHER 14. Maiden Name Unknown

15. Birthplace " "

16 (a) Informant Robert Johnson (Address) 1102 Kenilworth Portsmouth Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 9, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem. Location Brooklyn Md

18 (a) Funeral director Clay O. Wilson

(b) Address 1000 Blankenship

19 (a) MAR 9 1948 (Date rec'd by registrar) (b) Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1948, at 9:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial degenera-tion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royster M.D. Medical Examiner

Date signed 3-5-48

VS 181

C61016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. C61016

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3-0 ✓
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) One
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 Duke Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta G. PIERCE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: George Pierce

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years 37 CMT | Months | Days | If less than one day hr. min.

9. Birthplace New Kent Co. Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Willie Ray
13. Birthplace unknown

MOTHER
14. Maiden Name Lucas Codwell
15. Birthplace New Kent Co. Va.

16 (a) Informant Julia Bolden
(b) Address 731 S. Spring St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 10-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem.
Location Brooklyn Md

18 (a) Funeral director Elroy S. Wilson
(b) Address 1000 Bentley ave

19 (d) MAR 9 - 1948 (Date rec'd by registrar) Waiting for Affidavit Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1948, at 2 30 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 3/5/48

VS 191

66-1017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registration No. 66-1017

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1028 E. Eager
(c) Hospital or institution: 7-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1028 E. Eager
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eunice Tolbert Washington Anthony

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Rev James A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/16/1902

8. AGE: Years 46 | Months 1 | Days 21 | If less than one day hr. min.

9. Birthplace Augusta, Ga
(Town, county, and state)

10. Usual Occupation H. Wife

11. Industry or business

FATHER 12. Name Richard Johnson

13. Birthplace Augusta Ga

MOTHER 14. Maiden Name Hattie Baker

15. Birthplace Ga

16 (a) Informant Rev James A. Anthony

(b) Address 1028 E. Eager St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 (month) / 9 (day) / 48 (year)

(c) Cemetery or crematory Gilmores

Location Md

18 (a) Funeral director Key H. Kelsoe

(b) Address 1303 Presstman St

19 MAR 9 - 1948 (Date rec'd by registrar) Huntingtown, Williams, Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 March 1948, at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5 March 1948 to 6 March 1948 and that I last saw h.. alive on 6 March 1948.

Immediate cause of death
Acute Coronary Occlusion — Duration 1 day

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address 2309 Druid Hill Ave Date signed 3-9-48

VS 150

X

61018

AB-116572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 13B

Registered No. G61018

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 15-01

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 627 Cumberland St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Edward Watts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16 1894

8. AGE: Years	Months	Days	If less than one day
53	9	21	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER

12. Name Joe Watts (D

13. Birthplace Maryland

MOTHER

14. Maiden Name Jeannie Presco (D

15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director Geo. B. Kelson

(b) Address 1303 Pleasant Ave

19 (a) MAR 8 1948 (Date received by registrar) (b) Huntingtown, Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1948, at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-14- 1948 to 3-6- 1948, and that I last saw him alive on 3-6- 1948

Immediate cause of death Far-advanced Bilateral Pulmonary Tuberculosis — Duration 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.

Address Baltimore City Hosp Date signed 3-7-48

VS 150

G1019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G61019
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 17-01
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 8

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 828 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Sheppard Haygen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/1898

8. AGE: Years 49 | Months 8 | Days | If less than one day hr. min.

9. Birthplace St. Mary County Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Clem Hayden
13. Birthplace Md

MOTHER
14. Maiden Name Lana Hensley
15. Birthplace Md

16 (a) Informant James Haygen
(b) Address 1350 Fremont St

17 (a) Burial (b) Date thereof 3/10/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Md.

18 (a) Funeral director Geo. D. Nelson
(b) Address 1303 Pressstman St

19 (a) (Signature of local registrar) (b) Herrington Willis Registered No.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6 1948 at 12 00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6 1948 to 3/6 1948 and that I last saw him alive on 3/6 1948

Immediate cause of death: Shock and Toxemia — Duration: 12 hrs

Due to 2nd & 3rd degree burns of body face and neck — 12 hrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: Yes
(a) Accident, suicide, or homicide? Accident
(b) Date of occurrence 3/6/48 at 12 00 A.M.
(c) Where did injury occur? Baltimore Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Burns Gasoline ignited while smoking Burn afire - Fell

23. Signature O. W. Hoffler M.D.
Address Provident Hosp Date signed 3/6/48

To W. B. Davis by X
Howard J. Madden M.D.

Dr. Davis

061020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 061020

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address an street in front of 3701 Belvedere Ave
(c) Hospital or institution: D.O.A. West Balto. Gen'l. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3720 W Garrison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Sherman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
W	M	Married

6 (b) Name of husband or wife Ethel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Ethel Sherman
(b) Address 3720 W Garrison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philp Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) Date received by registrar 3-9-48 (b) Signature for Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1948, at 1:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary Disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Harman J. Williams M.D.
Medical Examiner.
Date signed 3-9-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Spell out full name, residence and birthplace. Give correct age in years, months and days. Occupation should indicate the trade, profession or particular kind of work done, even if deceased was retired or a housewife. Industry or business should indicate the name of the establishment in which deceased was employed. Physicians: please write the causes of death clearly and legibly. Cause of death as entered by physician is especially important.

61021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 61021

107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2636 E. Oliver St

(c) Hospital or institution: 8.03

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2636 E. Oliver St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country.

3 (a) FULL NAME George Leo Allen

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-18-8148

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edna O. Allen

6 (c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): Oct-22-1901

8. AGE: Years: 46 | Months: 4 | Days: 15 | If less than one day: hr. min. 17

9. Birthplace: Balto Md (Town, county, and state)

10. Usual Occupation: Stock Clerk

11. Industry or business: Rustless Steel Co.

FATHER

12. Name: Wm H. Allen

13. Birthplace: Balto. Md.

MOTHER

14. Maiden Name: Laura M. Batchelor

15. Birthplace: Balto Md

16 (a) Informant: Edna O. Allen

(b) Address: 2636 E. Oliver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3-11-'48 (month) (day) (year)

(c) Cemetery or crematory: Baltimore Cem.

Location: North Ave

18 (a) Funeral director: John C. Mellor Inc

(b) Address: 2455 E. Oliver St

19 (a) 3-9-1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-8-1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 8 1948, to Mch 8 1948, and that I last saw him alive on Mch 8 1948.

Immediate cause of death: Bronchopneumonia — Duration: 1 week

Due to:

Due to:

Other Conditions: (Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide: at M

(b) Date of occurrence:

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury:

23. Signature: Jacob Frisher, M. D.

Address: 1623 N. Wash. St. Date signed: 3/8/48

VS 150

G61022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G61022

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use typewriter if possible. Do not write the causes of death clearly and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No. 58 Carroll St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur L Bowers

3 (b) If veteran, name war

3 (c) Social Security Account No. SS. 214-01-1731

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Fisher Bowers | 6 (c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.) 4-25-04

8. AGE: Years 43 | Months 10 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name (Lewis G.) Sargent Bowers
13. Birthplace Md

MOTHER — 14. Maiden Name Cora May Bowers
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/48 (month) (day) (year)
(c) Cemetery or crematory Kriders
Location Carroll Co. Maryland

18 (a) Funeral director J. Francis Resp
(b) Address Westminster Md.

19 (a) Mar 9th 1948 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-8- 1948, at 2 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-8- 1948 to 3-8- 1948 and that I last saw h[illegible] alive on 3-5-48

Immediate cause of death ? ventricular fibrillation

Due to Syphilitic aortic disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Douglas B Reaver
Address Johns Hopkins Hosp. Date signed 9 March 1948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G6.1023

G6.1023

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert Sts

(c) Hospital or institution: Union Memorial Hospital 9-03

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days

(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3921 Elm Rd. (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Mary L. Wollering, Sr (MARY LOUISE WOLLERING)

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
NO	NONE	F	W	Married

6 (b) Name of husband or wife Mr. John L. Wollering Sr

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) August 4, 1890

8. AGE: Years 57 | Months 7 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER 12. Name John L. Hayes

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Theresa ? (unknown)

15. Birthplace Germany

16 (a) Informant Mr. John L. Wollering Sr.

(b) Address 372 Elm Rd, Balto. 18, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/10/48 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery

Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.

(b) Address NORTH AVE. & BROADWAY

19 (a) MAR 9 1948 (Date rec'd by registrar) (b) Transcription from Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-6 1948, at 3.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19__ to 3-6 1948, and that I last saw h.er alive on March 6 1948

Immediate cause of death Heart Failure

Due to Cerebral Vascular Accident

Due to Hypertensive C.V. Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Coronary Sclerosis

Duration
21 days
many yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature John R. Smith, Jr. M.D.

Address Union Memorial Hosp Date signed 3/8/48

VS 150

61024 JL - 61499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 61024

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made on this certificate before it is filed. Physicians: please write the causes of death clearly and legibly. Give full name of deceased. Do not use initials. Be sure that age, color, and birthplace are correctly stated. Be sure that cause of death is stated so that it can be understood by a stranger. Do not abbreviate. Do not use terms of locality or physician's personal knowledge. Be sure that correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 3-0 ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 310 S. Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Carbonaro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Marie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1879

8. AGE: Years	Months	Days	If less than one day
68	3	5	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Amato Carbonaro
13. Birthplace Italy

MOTHER
14. Maiden Name Eda ?
15. Birthplace Italy

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 3/10/1948. (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road.

18 (a) Funeral director Wendell Hempel
(b) Address 312 S. Highland Ave. Washington, Mo.

19 (a) [illegible] by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1948, at 5.15AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 2 1940 to Mar. 7 1948, and that I last saw h imalive on March 7 1948.

Immediate cause of death	Duration
Occlusion of left coronary Cathy	?
Due to arteriosclerosis	year
Due to myocardial infarction, old	?
Due to about, Cardiac insufficiency & Pulmonary edema	?
Other Conditions Cerebral Ischemia.	?
Accident, old & right hemiparesis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide at M
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laurence Lee Jr. M. D.
Address Baltimore City Hosp Date signed 3-2-48

X

64025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. 64025

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be correct are is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution: Bon Secours 20-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1941 W Fayette St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Miss. Mary C. McNulty

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16 1870

8. AGE: Years	Months	Days	If less than one day
69	7	23	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business

FATHER
12. Name John J. McNulty
13. Birthplace Md

MOTHER
14. Maiden Name Rose Murphy
15. Birthplace Eng Ireland

16 (a) Informant Mrs. Charles R. Broderick
(b) Address 941 W Fayette st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-11-48 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Govts Md

18 (a) Funeral director Geo A Fahey
(b) Address Fenton Ave & Fayette

19 (a) MAR 9 1948 (Date rec'd by registrar) (b) Century for Wilmarth, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-8-48 19..., at 8 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 27 1948, to March 6 1948, and that I last saw HER alive on March 6 1948

Immediate cause of death	Duration
Generalized debility from carcinomatosis	
Due to Carcinoma of recto-sigmoid &	
Due to: metastasis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 2/21/48
Major findings of operation: Ca. of recto-sigmoid & metastases
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Carl C. Drennon M. D.
Address Bon Secours Hosp. Date signed 3/7/48

VS 150

G61026

BALTIMORE CITY HEALTH DEPARTMENT

48-04238 CERTIFICATE OF DEATH 157E

Registered No. G61026

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be answered. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hospital
(c) Hospital or institution: 2025 West Fayette St. Baltimore
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 19-03

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 226 S. Stricker St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy McCrea Donohue

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/25/48

8. AGE: Years	Months	Days	If less than one day
		13	hr. min.

9. Birthplace Bon Secours Hospital (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Patrick Donohue
13. Birthplace Md

MOTHER
14. Maiden Name Helen Anne Farrell
15. Birthplace Balto.

16 (a) Informant John G. Donohue
(b) Address 226 S. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-11-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto.

18 (a) Funeral director George A. Farley
(b) Address Fulton Ave & Fayette St

19 (a) MAR 9 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1948, at 10:44 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 25 1948, to March 9 1948, and that I last saw him alive on March 7 1948.

Immediate cause of death	Duration
Respiratory failure	
Due to Terminal pneumonia	
Due to	
Other Conditions Severe congenital heart disease	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William F. Barr M. D.
Address Date signed 3-9-48

VS 150

66027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

✓ Registered No. 66027

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 302 Mosher St
(c) Hospital or institution: 14-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 302 Mosher St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Madden

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1871

8. AGE: Years	Months	Days	If less than one day
76 77	9	20	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Patrick Madden
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Barry
15. Birthplace Ireland

16 (a) Informant Catherine M. Duffy
(b) Address 302 Mosher St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Fredrick Rd

18 (a) Funeral director John G. Moran
(b) Address 3060 E. Baltimore St.

19 (a) MAR 10 1948 (Date rec'd by registrar) (b) Huntingtown Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7th 1948, at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1948 to Mch 7 1948, and that I last saw h[er] alive on Feb 17 1948.

Immediate cause of death: General abdominal adhesions — Duration at least 6 yrs.
Due to Old age
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J W Keown M. D.
Address 1938 Linden Ave Date signed 3/7/48

VS 150

over

X

61028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 548

Registered No. 61028

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun St
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Worcester
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 809 Boardwalk Ocean City Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME William A. Duke.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Married

6 (b) Name of husband or wife Virginia Agnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9 1888

8. AGE: Years	Months	Days	If less than one day
59	5	29	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Real Estate
11. Industry or business

FATHER
12. Name Charles A. Dukes
13. Birthplace Maryland

MOTHER
14. Maiden Name Esther V. Fully
15. Birthplace Maryland

16 (a) Informant Virginia Dukes
(b) Address 809 Boardwalk Ocean City Md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-11-48 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Bowie
Location
18 (a) Funeral director John G. Moran
(b) Address 3980 E. Balt. St.
19 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 8 1948 at 3:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-23 1948 to 3-8 1948 and that I last saw him alive on 3-8 1948.

Immediate cause of death Terminal Bronchio-pneumonia — Duration

Due to Generalized Carcinomatosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Dec 1947

Major findings of operation: Ca of Prostate

of autopsy: Yes Carcinomatosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph B. Schwab
Address Franklin Sq. Hosp. Date signed 3-9-48 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

61029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

Registered No. 661029

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address W-04
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 Arson Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eugene GUTKOSKI

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife MARY

6 (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) 1915

8. AGE: Years 33 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace GARY. W.VA (Town, county, and state)

10. Usual Occupation TAXI DRIVER

11. Industry or business —

FATHER
12. Name ANDREW GUTKOSKI
13. Birthplace

MOTHER
14. Maiden Name —
15. Birthplace

16 (a) Informant G.W. FISHPAW
(b) Address 470 NORTHBEND Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 10 48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cemetery
Location

18 (a) Funeral director MARTIN CONROY
(b) Address 1000 HOLLINS ST

19 MAR 10 1948 Huntington Williams M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-7-1948, at 8 A.M. 33

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary arteriosclerosis
Acute congestive heart failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 3/8/48

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

661030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 661030

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. Be sure to give correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp. 9-07
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19d
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2603 Garrett Ave. City 18
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Frank M. Hamar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife Marjorie Hamar
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 26 1896

8. AGE: Years	Months	Days	If less than one day
53	1	12th	hr. min.

9. Birthplace Maryland
(Town, county and state)

10. Usual Occupation Auto mechanic

11. Industry or business

FATHER
12. Name James H. Hamar
13. Birthplace Md.

MOTHER
14. Maiden Name Josephine Hamar
15. Birthplace Md

16 (a) Informant Wife
(b) Address 2603 Garrett Ave City 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 12 48 (month) (day) (year)
(c) Cemetery or crematory Spring Hill Cemy
Location Easton Md

18 (a) Funeral director John O. Mitchell & Son
(b) Address 1966 Eutaw Place

19 MAR 10 1948 Registered by Wallace Williams M.D. Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 March 1948 at 10:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18 1948 to 9 May 1948 and that I last saw h[illegible] alive on 9 Mar 1948

Immediate cause of death: Circulatory collapse — Duration

Due to: Carcinomatosis

Due to: Carcinoma colon.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 24 Feb 48

Major findings of operation: Inoperable carcinoma of colon

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. Johnson III M. D.
Address Union Memorial Hosp. Date signed 9 Mar 48

VS 150

X

G61031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

Registered No. G61031

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3816 Sequoia Ave.

(c) Hospital or institution: none 15-10

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County none

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3816 Sequoia Ave. (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Alexander V. Owens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary A. Dettor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 9, 1868

8. AGE: Years	Months	Days	If less than one day
79	2	27 29	hr. min.

9. Birthplace Anne Arundel County, Md. (Town, county, and state)

10. Usual Occupation merchant tailor - retired

11. Industry or business

FATHER

12. Name Alex Owens

13. Birthplace Anne Arundel County, Md.

MOTHER

14. Maiden Name Elizabeth Hardesty

15. Birthplace Anne Arundel County, Md.

16 (a) Informant Mrs. Mary D. Owens

(b) Address 3816 Sequoia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/10/48 (month) (day) (year)

(c) Cemetery ~~cemetery~~ Druid Ridge

Location Pikesville, Md.

18 (a) Funeral director John Mitchell & Sons, Inc.

(b) Address 1900 Eutaw Place

19 MAR 10 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 7 1948 at 10P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/16/48 19 to 3/7 1948, and that I last saw him alive on 3/7 1948.

Immediate cause of death	Duration
acute Heart failure	1 day
Due to Chronic Myocarditis	1 year
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. E. Pouleton M.D.

Address 3909 Lawson Date signed 3/9/48

J. E. Pouleton M.D.

661032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. 661032

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution: Union Memorial Hospital 27-11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County —
(c) City or town Baltimore — 10
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 Overhill Road
(If rural give location)
(e) Citizen of foreign country? U.S. (Yes or No)
If yes, name country —

3 (a) FULL NAME JOHN OSCAR ROBINSON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Margaret E. Robinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-13-1873

8. AGE: Years	Months	Days	If less than one day
74	2	24	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Drug Company President
11. Industry or business

FATHER
12. Name George Robinson
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Robinson
15. Birthplace Maryland

16 (a) Informant Mrs Margaret E. Robinson
(b) Address 108 Overhill Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 11 '48 (month) (day) (year)
(c) Cemetery or crematory David Ridge Bay
Location Pikesville Balto Co. Md.

18 (a) Funeral director John S. Mitchell Sons
(b) Address 4 E Centre Place

MAR 10 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-8 1948, at 2:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4 1948, to 3-8 1948, and that I last saw him alive on 3-8 1948

Immediate cause of death: Carcinoma of rectum
2 months 2 days

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James M'C. Fleming M. D.
Address Union Memorial Hop. Date signed 3-8-48

VS 150

X

661033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

135 B

Registered No. 661033

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Prince Geo.
(c) City or town Laurel
(If outside city or town limits, write RURAL and give town)
(d) Street No. 408 Laurel Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Winnie L. Hicks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Irene Hicks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1880

8. AGE: Years 67 | Months 10 | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace Cambridge, Md
(Town, county, and state)

10. Usual Occupation Attendant

11. Industry or business District Training School

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Sally Harper
15. Birthplace Md

16 (a) Informant Mrs Irene Hicks
(b) Address 408 Laurel Ave. Laurel Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 12/48 (month) (day) (year)
(c) Cemetery or crematory Fredericksburg
Location Fredericksburg, Md.

18 (a) Funeral director W. Hyatt Donaldson
(b) Address Laurel Md

MAR 10 1948 (Date rec'd by registrar)

(b) Huntington for Williams Mortuary

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 9 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1948 to March 9 1948, and that I last saw him alive on 3/9 1948.

Immediate cause of death	Duration
Shock	
Due to — Cause unknown —	
Due to Urinary retention	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F. Benson M. D.
Address Univ. Hosp. Date signed 3/9/48

PLEASE WRITE PLAINLY, with ink or indelible pencil. Physicians: please write the causes of death clearly and correct age is especially important.

VS 150

John F. Benson

1034 JL - 111391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G61034 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 10-01
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 Stirling St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Chester Hopkins

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1901

8. AGE: Years	Months	Days	If less than one day
47	-	10	hr. min.

9. Birthplace Ill (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Moses Hopkins
13. Birthplace Ky

MOTHER
14. Maiden Name Ollie Capenhaver
15. Birthplace Ky

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 12-48 (month) (day) (year)
(c) Cemetery or crematory
Location Springfield Ill.

18 (a) Funeral director Cloyd Wilson
(b) Address 1600 Baltimore ave

MAR 10 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1948, at 4.45AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 13 1947, to March 7 1948, and that I last saw h im alive on March 7 1948.

Immediate cause of death	Duration
Uremia, terminal, and	5 weeks
Pulmonary edema	? weeks
Due to Chron. Congestive heart failure	1-2 yrs.
Due to Arteriosclerotic and ? Rheumatic Heart Disease.	years ?
Other Conditions Bronchiectasis; Chronic Passive Congestion of Liver.	

(Include pregnancy within 3 months of death)

Date of operation 9-2-47
Major findings of operation: Cyst of palate removed.
of autopsy: Same

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp Date signed 3-8-48

VS 150

PLEASE WRITE PLAINLY. correct age is especially important. Physicians: please write the causes of death clearly.

661035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 152

Registered No. 661035

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 32nd and Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3½ weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Govkopville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Children's Rehabilitation Institute
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/14/1939

8. AGE: Years	Months	Days	If less than one day
9	4	25	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Michael J. Kelly
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Clare E. Brown
15. Birthplace Pennsylvania

16 (a) Informant Parents
(b) Address Pennsylvania 1043 Monroe Ave Scranton, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-18-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Scranton, Penna.

18 (a) Funeral director George A. Farley
(b) Address Fulton Ave & Fayette St.

MAR 10 1948 (Date received by registrar) (c) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1948, at 5 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 5 1948 to March 9 1948, and that I last saw her alive on March 5 1948.

Immediate cause of death	Duration
Septicemia (Hemolytic staphylococcus aureus)	4 days
Due to Ecchalitis of tongue	4 days
Due to trauma to tongue (cause of trauma) Unk.	5 days
Other Conditions Generalized athetoid spasticity	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Katherine Spaeth M. D.
Address Union Memorial Hosp. Date signed 3/9/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

661036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 661036

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1809 Ensor St
(c) Hospital or institution: D.O.A. 9-09
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 Ensor St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John M. Agnew

3 (b) If veteran, name war: W. W. #1

3 (c) Social Security Account No. 219-20-6383

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
M	W	Married

6 (b) Name of ~~husband or~~ wife Thelma E. Agnew

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6th 1885

8. AGE: Years	Months	Days	If less than one day
63	2	2	hr. min.

9. Birthplace Florida
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Thomas V. Agnew
13. Birthplace Fla.

MOTHER
14. Maiden Name Mary Polzi
15. Birthplace

16 (a) Informant Thelma E. Agnew
(b) Address 1809 Ensor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/48 (month) (day) (year)
(c) Cemetery or crematory U. S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

MAR 10 1948 (Date rec'd by registrar) (b) Huntington Williams M.E. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8 19 48 at 8:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. A. Subranski M.D.
Medical Examiner.
Date signed 3/8/48

PLEASE WRITE PLAINLY. Items ... correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

1037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

C61037

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Use "None" or "Unknown" where necessary. Physicians: please write the causes of death clearly and legibly. Give full name of deceased, and do not use initials. Do not abbreviate. Write out the full name of the street, and number of house. Give the usual residence of deceased, whether inside or outside city limits, and write RURAL if outside city or town limits. Give the name of the city or town, and do not use the name of a township. Fill in all blanks with the information required. If the deceased was married, widowed, or divorced, state the name of husband or wife. If a child, state the name of father or mother. Give the date of birth in ordinary figures, stating the day, month, and year. Give the age at last birthday in years, months, and days. If less than one day, state the hours or minutes. Give the birthplace, stating the town, county, and state. Give the usual occupation of each person, even of those who have retired from business or trade. Also give the name of the business or employer. Write the cause of death clearly and legibly. Give the full name and address of informant. Give the date of burial, cremation, or removal. Give the name of the cemetery or crematory. Give the name and address of the funeral director. The certificate must be filled out, signed, and returned to the Registrar of Vital Statistics before a burial permit will be issued.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3615 W Garrison Ave
(c) Hospital or institution: 27-18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3615 W Garrison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isadore Charson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Whiye	Married

6 (b) Name of husband or wife Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Merchant

FATHER
12. Name Lazer Charson
13. Birthplace Russia

MOTHER
14. Maiden Name Unkown
15. Birthplace Russia

16 (a) Informant Mrs Minnie Charson
(b) Address 3615 W Garrison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March, 10, (month) (day) (year)
(c) Cemetery or crematory Anshei Emunah Cong Cem
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 MAR 10 1948 (b) Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1948 at 1 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1946 to 3/3 1948 and that I last saw h. w. alive on 3/3 1948.

Immediate cause of death Acute Coronary infarction
Due to Ch Coronary Sclerosis
Due to Ch Diabetes
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature A. L. Hornstein M. D.
Address 204 E. Biddle St Date signed 3/10/48

VS 150

94a

661038

661038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 94a

PLEASE WRITE PLAINLY; ink required. Physicians: please write the causes of death clearly and accurately; correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Sinai Hospital
(b) Street address — Monument & Rutland Ave
(c) Hospital or institution: 15.04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2126 W North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** WILLIAM STEINBERG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jennie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 72 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Tailor

11. Industry or business

FATHER
12. Name: Morton Steinberg
13. Birthplace: Russia

MOTHER
14. Maiden Name: Clara ?
15. Birthplace: Russia

16 (a) Informant: Mrs Jennie Steinberg
(b) Address: 2126 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 10, 1948 (month) (day) (year)
(c) Cemetery or crematory: Arlington Cemetery
Location: Rogers Ave

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 MAR 10 1948 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Mar 1948, at 9 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 Mar 1948, to 9 Mar 1948, and that I last saw h[illegible] alive on 5 Mar 1948.

Immediate cause of death: Myocardial infarction

Due to: Coronary occlusion

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Bernard L Cohen M. D.

Address: Sinai Hosp, Balto 5 Md Date signed 9 Mar

X

1065039 Death Certificate 48-03940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 161a

Registered No. 1065039

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 108 S Fulton avenue
(c) Hospital or institution: 19-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 108 S. Fulton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dona M. Russell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1948

8. AGE: Years	Months	Days	If less than one day
		16	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Charles O. Russell

13. Birthplace Maryland

MOTHER 14. Maiden Name Naomi F. Landis

15. Birthplace Virginia

16 (a) Informant Charles O. Russell

(b) Address 108 South Fulton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 10, 1948 (month) (day) (year)

(c) Cemetery or crematory Glen Haven Mem.

Location Balto Co. Md

18 (a) Funeral director Pratt & B.M. Walter

(b) Address Pratt & Chuckas Sts

19 (a) MAR 10 1948 (Date rec'd by registrar) (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1948, at 9A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Pulmonary atelectasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L Boyer M.D. (Medical Examiner)

Date signed 3-9-48

PLEASE WRITE PLAINLY. Physicians: please write the cause of death in such a manner that correct age is especially important.

VS 181

X

040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C61040

1170

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 631 Melville Avenue
(c) Hospital or institution: 9.03
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 631 Melville Avenue
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME George A. Voith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Frances (nee Uher)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1891

8. AGE: Years	Months	Days	If less than one day
56	11	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Own Business
11. Industry or business

FATHER
12. Name Anthony Voith
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Protzmann
15. Birthplace Baltimore, Md.

16 (a) Informant George J. Voith - son
(b) Address 631 Melville Avenue

17 (a) Burial (b) Date thereof 3/11/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

MAR 10 1948 Huntington Williams M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 7th 1948, at 6.40 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1, 1948 to Mar 7, 1948 and that I last saw h[illegible] alive on Mar 7 1948.

Immediate cause of death
Cardiac thrombosis
Due to Arterio Sclerosis
Due to
Other Conditions Gastric ulcer - recurrent
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

Duration
15 Mins ago
Burn
2 wks

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. F. Hyerkins
Address 8 E. 39th St Date signed 3/9/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

VS 150

94a

61041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

61041
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 812 Register Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Rebecca Kleffman

3 (b) If veteran, name war: —

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife: JOHN FREDERICK

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/15/1862

8. AGE: Years 85 | Months 2 | Days 24 | If less than one day hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name JOHN BRUNS
13. Birthplace GERMANY

MOTHER
14. Maiden Name REBECCA REDECKE
15. Birthplace GERMANY

16 (a) Informant MRS. MARGURITE BARRON
(b) Address 3205 PRESSTMAN ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/11/48 (month) (day) (year)
(c) Cemetery or crematory St. Paul's LUTHERN
Location VIOLETSVILLE MD.

18 (a) Funeral director Wm. J. TICHNER & SONS
(b) Address BALTIMORE MD

19 MAR 10 1948 (Date received by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8 1948 at 9:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6 1948 to 3/8 1948 and that I last saw h[illegible] alive on March 8 1948.

Immediate cause of death Cerebral Hemorrhage

Due to Cerebral Thrombosis

Due to Arteriosclerosis hypertension Cardiovascular Disease

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Redwood & Greene Date signed 3/9/48

PLEASE WRITE PLAINLY. Physicians: please write the cause of death clearly and correct age is especially important.

VS 150

937

1042

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. C61042

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 HILTON RD.
(c) Hospital or institution: ASHBURTON NURSING HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 09
(e) Length of stay in Baltimore (yrs., mos., or days) 15 09

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2842 CLIFTON AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELLA FLORENCE STEVENS

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: SINGLE
6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 2, 1862

8. AGE: Years 85 | Months 3 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace BALTO., MD (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name WILLIAM H. STEVENS
13. Birthplace MD.

MOTHER
14. Maiden Name ELIZABETH R. TUDER
15 Birthplace MD.

16 (a) Informant MRS. ELLA J. COUNCELL-NEICE
(b) Address 2314 ALLENDALE, RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/10/48 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE CEM
Location BALTO., MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTIMORE, MD.

19 MAR 10 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8/48 19__, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 18 1946 to March 8 1948 and that I last saw h.er alive on March 8 1948.

Immediate cause of death: Arteriosclerosis
Cerebral " Sclerosis — Duration 2 yrs

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. G. Jones M.D.
Address 2818 St. Paul St. Date signed 3/9/48

PLEASE WRITE plainly. Use ink. Do not use pencil. Be sure to give correct age in each case. Data concerning parents is especially important. Physicians: please write the causes of death clearly.

VS 150

1043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. C61043

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: WEST BALTO. GEN'L
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 01

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4806 LIBERTY HGTS AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** MRS. HAZEL M. BROCKMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	No	F	W	MARRIED

6 (b) Name of husband or wife HENRY J. BROCKMAN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 19, 1893

8. AGE: Years	Months	Days	If less than one day
54	9	19	hr. min.

9. Birthplace BALTO., MD. (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name THEODORE A. STURM
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name LOUISA M. WATTS
15. Birthplace BALTO MD

16 (a) Informant MR. HENRY J. BROCKMAN
(b) Address 4806 LIBERTY HGTS AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/11/48 (month) (day) (year)
(c) Cemetery or crematory LONDON PK.
Location BALTIMORE, MD.

18 (a) Funeral director WM. J. TICKER & SON
(b) Address BALTO. MD.

19 MAR 10 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 8, 1948 at 11:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/8 1948 to 3/8 1948, and that I last saw HER alive on 3/8 1948.

Immediate cause of death CEREBRAL HEMORRHAGE — Duration
Due to HYPERTENSIVE VASCULAR DISEASE
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Gerbutchy, M.D.
Address West Baltimore General Hosp. Date signed 3/9/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

VS 150

61044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G61044 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 13-03
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Garage - Rear of 3529 Frances St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Linderman

3 (b) If veteran, name war: None
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1881

8. AGE: Years	Months	Days	If less than one day
66	2	12	14 hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name James Linderman
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Laura Klein
15. Birthplace Balto. Md.

16 (a) Informant Mr. Jacob Linderman
(b) Address 1736 N. Bradford St.

17 (a) Burial (b) Date thereof 3/11/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Milton + Rose Sts.

18 (a) Funeral director Howard N. Bright Jr.
(b) Address 4914 Belair Road

19 MAR 10 1948 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8 1948, at 4:00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Jaskowski M.D.
Medical Examiner.
Date signed 3/9/48

PLEASE PRINT. Physicians: please write the cause of death in such a way, correct age is especially important.

VS 181

5045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C65045

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 1-03
(d) Length of stay in hospital or inst. (yrs., mos., or days): 3 days
(e) Length of stay in Baltimore (yrs., mos., or days): 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 719 S. Lakewood Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: William Worhouse Nuckolls

3 (b) If veteran, name war: —
3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Apr. 29, 1873

8. AGE: Years	Months	Days	If less than one day
74	10	9 10	hr. min.

9. Birthplace: Bates Co. Mo.
(Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business:

FATHER
12. Name: Charles Nuckolls
13. Birthplace: Va.

MOTHER
14. Maiden Name: Susan Barbar
15. Birthplace: NC

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 11-48 (month) (day) (year)
(c) Cemetery or crematory: New Balto. National Cem.
Location: Frederick Rd.

18 (a) Funeral director: John L. Miller
(b) Address: 2334 Jefferson St.

19 (a) MAR 10 1948 (b) Huntington Williams, M.D. Registrar
(Registered by local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9 1948, at 7:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 6 1948 to Mar. 9 1948, and that I last saw him alive on Mar. 9 1948.

Immediate cause of death	Duration
Hypertensive cardiovascular disease with cardiac hypertrophy and	Unknown
Due to failure	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson Sr. Surgeon
Address: Clinical Director Date signed 3/9/48 M.D.

PLEASE WRITE PLAINLY. Physicians: please write the cause of death carefully. Accurate and correct age is especially important.

G61046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G61046

PLEASE WRITE PLAINLY, with unfading ink. Use no abbreviations. Do not leave any blanks. If unknown, or not applicable, write none. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4113 Chatham Road
(c) Hospital or institution: 15-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4113 Chatham Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah I. Chasin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Philip

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) , 1887

8. AGE: Years 61 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Harry
13. Birthplace Russia

MOTHER
14. Maiden Name Hannah
15. Birthplace Russia

16 (a) Informant Philip Chasin
(b) Address 4113 Chatham Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Gutaw Place

19 MAR 10 1948 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-9-1948 at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1947 to 3/9 1948
and that I last saw h.[illegible] alive on Mar 8 1948

Immediate cause of death: Carcinoma of Gallbladder — Duration: 8 Months

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alan Bernstein M. D.
Address 110 W Calvert Date signed 3/10/48

061047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 061047

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 11-03
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 days
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 W. Monument St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Viola Morris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/11/01

8. AGE: Years	Months	Days	If less than one day
46	8	28	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name unknown
13. Birthplace " "

MOTHER
14. Maiden Name unknown
15. Birthplace " "

16 (a) Informant Viola Morris
(b) Address 415 W Monument

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 11-1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Mem
Location Brooklyn Md

18 (a) Funeral director Elrod D. Wilson
(b) Address 1000 Brentley ave

19 MAR 10 1948 (Date rec'd by registrar) (b) Hunting for Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8 1948, at 12:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/30 1948 to 3/8 1948 and that I last saw her alive on 3/7 1948

Immediate cause of death: Metastatic Carcinoma — Duration:
Due to Carcinoma of breast — 2 yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 1936
Major findings of operation: Carcinoma of breast
of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature O. W. Hoffler M.D.
Address Provident Hosp. Date signed 3/8/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Spell out full words. Do not use abbreviations. Make entries in all spaces. If none, write "None." Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

1048 Color: C admitted 4:00 P.M.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 6

G61048 Registered No. new

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 7-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 921 Shuter St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Pryor ✓
3 (b) If veteran, name war
(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	colored	single

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
13 years			hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Isaac Pryor
13. Birthplace ?

MOTHER
14. Maiden Name Lillian Douglas
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 12-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn Md

18 (a) Funeral director Chas S Wilson
(b) Address 1000 Baltimore ave

MAR 10 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/9 1948, at 4:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/9 1948 to 3/9 1948, and that I last saw him alive on 3/9 1948.

Immediate cause of death	Duration
Meningococcus Meningitis	1½ days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Peter O Steiner
Address JHH Date signed 3/11 M.D.

correct age is especially important. Physicians, please

VS 150

049 Res Maryland

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. 661049

PLEASE WRITE PLAINLY, WITH UNFADING INK. Either print or type. Use only black ink. Do not abbreviate. Give full name of street or number. Do not use ditto marks. Be sure to answer all questions. Be sure to give correct age in each case. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 365 W Preston St
(c) Hospital or institution: 11-64
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 365 W. Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henrietta Potts

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace Trapp Talbot Co. Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Bill Askins
13. Birthplace Trapp Talbot Co. Md

MOTHER
14. Maiden Name Sarah Askins
15. Birthplace Trapp. Talbot Co. Md

16 (a) Informant Lillie Gray
(b) Address 365 W. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 10-1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Cem.
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly ave

19 (a) MAR 10 1948 (b) Huntington Williams MD
Date rec'd by registrar

3-6-48 **MEDICAL CERTIFICATION** 12:45 pm

20. DATE OF DEATH March 6 1948, at 1245 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to March 6 1948 and that I last saw h... alive on March 6 1948

Immediate cause of death — Duration
(a) Carcinoma Rectum — 2
Due to
(b) Carcinoma of Uterus
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 3-6-48

V S 150

61050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

061050

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 624-George St.

(c) Hospital or institution: 17.01

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 624-George St. (If rural, give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Irby.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 15 1910

8. AGE: Years 38 | Months | Days 21 | If less than one day hr. min.

9. Birthplace Richmond Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

MOTHER / FATHER

12. Name Sam Irby

13. Birthplace Va

14. Maiden Name Mary Johnson

15. Birthplace Va

16 (a) Informant Mary Gallaway

(b) Address 624 E Geneva St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-1948 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location

18 (a) Funeral director A. Halstead

(b) Address 918 Druid Hill Ave

(a) (Date rec'd by registrar) MAR 10 1948 (b) Registrar Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-8-1948 at M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 4 1948 to March 8 1948 and that I last saw him alive on March 7 1948

Immediate cause of death Acute Lobar pneumonia — Duration 2 months

Due to

Due to

Other Conditions Acute Asthma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. O. Stewart M. D.

Address 632 W Franklin St Date signed

PLEASE WRITE PLAINLY. Physicians: please write the causes of death in terms which will correct age is especially important.

VS 130

X

61051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G61051

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2027 W. Baltimore St
(c) Hospital or institution: 20-03
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2027 W. Baltimore St
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Louisa Orem Brown

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: late John R. Brown

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov. 2 - 1861

8. AGE: Years 86 | Months 4 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name William Orem
13. Birthplace Md

MOTHER
14. Maiden Name Katherine Miller
15. Birthplace Md

16 (a) Informant Mrs Adkin H Brown
(b) Address 2027 W. Balto. St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 11 1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Geo L. Boyer Jr
(b) Address 1512 Hollins St

19 (a) MAR 10 1948 (Date rec'd by registrar) Washington Williamsville Md

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1948, at 6.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947 to Mar 8 1948 and that I last saw h alive on 3/7 1948

Immediate cause of death: Bronchopneumonia — Duration: 2 days
Due to: Fracture of Left Hip — 2 years
Due to: Senility
Other Conditions: Arterial Sclerosis

(Include pregnancy within 3 months of death)

Date of operation ____
Major findings of operation: ____
of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)
(e) Means of injury ____

23. Signature Chas A Cofer M.D.
Address 2145 W Balto St Date signed 3-9-48

Please correct age is especially important. Physicians: please write the cause of death

VS 159

51052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G61052 Registered No. 698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1625 Laurens St.
(c) Hospital or institution: 16-03
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) over 10 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 Laurens St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Maud Bly

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2-5-1911

8. AGE: Years 37 | Months 1 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business own home

FATHER 12. Name Wm. Bly

FATHER 13. Birthplace Va.

MOTHER 14. Maiden Name Martha Painter

MOTHER 15. Birthplace Va

16 (a) Informant Laura Bly

(b) Address 1625 Laurens St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/10/48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director Geo. W. Kelson

(b) Address 1303 Pennsylvania Ave

MAR 10 1948 (Date received by registrar) (b) Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-7-1948, at 9:30 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-5-1945 to 3-7-1948 and that I last saw h alive on 3-6-1948

Immediate cause of death	Duration
Pulmonary Tuberculosis	unknown
Due to unknown	
Due to	
Other Conditions Bronchial asthma	unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank A. Saunders M. D.

Address 1029 N. Stricker St Date signed 3-10-48

VS 150

Please write plainly. Physicians: please write correct age is especially important.

1053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G61053

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 827 N. Fulton Ave.
(c) Hospital or institution: 16-03
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 827 N. Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) V
If yes, name country

3 (a) FULL NAME David N. Staten

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-20-4973

4. Sex: Male | 5. Color or race: Colrd | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1926

8. AGE: Years 22 | Months 12 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Samuel A. Staten
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Myrtle Matthews
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Myrtle Staten
(b) Address 827 N. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-11-1948 (month) (day) (year)
(c) Cemetery or crematory Sebastian Meml. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Geo. H. Stulland
(b) Address 1631 Druid Hill Ave

19 (a) 3-9-1948 (Date rec'd by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 March 1948, at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10 Feb. 1948, to 7 March 1948, and that I last saw h[illegible] alive on 7 March 1948.

	Duration
Immediate cause of death: Lobar Pneumonia	1 mo.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanford O. Immenda M. D.
Address 2309 Druid Hill Ave Date signed 3-9-48

VS 150

61054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 61054

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1810 Madison Ave
(c) Hospital or institution: 14-03
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Balto County Md
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 Madison (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar Haynes
3 (b) If veteran, name war
3 (d) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Mary V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1898

8. AGE: Years	Months	Days	If less than one day
50	-	12	hr. min.

9. Birthplace Maryland (Town, county and state)
10. Usual Occupation Custodian
11. Industry or business

FATHER 12. Name	Lloyd Haynes
FATHER 13. Birthplace	Maryland
MOTHER 14. Maiden Name	Johanna Holiday
MOTHER 15. Birthplace	Maryland

16 (a) Informant Mrs. Mary V. Haynes
(b) Address 1810 Madison Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Location Baltimore Co. Md.
18 (a) Funeral director Chas. Sam. H. Hallgren
(b) Address 1631 Druid Hill Ave
19 MAR 10 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8/48 at 5 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 3/1/48 to 3/8/48
and that I last saw him alive on 3/5/48
Immediate cause of death
Duration
Due to Cerebral Apoplexy
Due to Paralysis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Burkett M. D.
Address 2429 N. Charles
Date signed 3/9/48

VS 150

61055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 661055

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 619 South Charles Street
(c) Hospital or institution: 22
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 619 So. Chas. Street (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME: CHRISTINA BOWMAN SMALLWOOD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 6, 1890

8. AGE: Years 57 | Months 10 | Days 3 | If less than one day hr. min.

9. Birthplace Cincinnati, Ohio (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jacob Bowman
13. Birthplace Tenn.

MOTHER
14. Maiden Name Martha Harris
15. Birthplace Tenn.

16 (a) Informant Ruth Shannon
(b) Address 619 South Charles Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk.
Location Arbutus, Maryland

18 (a) Funeral director Chas. R. Law
(b) Address 802 Madison Avenue

19 MAR 10 1948 (Date rec'd by registrar) (b) Huntington Whitiquer M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1948, at 12:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/24 1948 to 3/9 1948.
and that I last saw her alive on 3/9 1948.

Immediate cause of death Uraemia
Chronic Myocarditis
Uterine Bilions

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dan S Trawler M.D.
Address R.V.V. See Date signed 3/10/48

PLEASE WRITE PLAINLY, with ink. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

VS 150

X

G61056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G61056

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2917 St. Paul Street
(c) Hospital or institution: 12-07
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2917 St. Paul Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** GERTRUDE MEREDITH BIRMINGHAM

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
None	None	Female	White	Widowed

6 (b) Name of husband or wife John H. Birmingham
6 (c) If alive, give age ///years

7. Birth date of deceased (mo., day, yr.) July 4, 18 64

8. AGE: Years	Months	Days	If less than one day
83	8	5	hr. min.

9. Birthplace Baltimore County, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name John H. Kirkwood
13. Birthplace Maryland

MOTHER
14. Maiden Name Hannah Meredith
15. Birthplace Maryland

16 (a) Informant Miss Grace Birmingham
(b) Address 2917 St. Paul St., Balto., Md.

17 (a) Burial (b) Date thereof March 11, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory West Liberty Cemetery
Location Baltimore Co., Maryland

18 (a) Funeral director John Burns' Sons
(b) Address Towson, Maryland

MAR 10 1948
(Date rec'd by registrar)

(b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1948, at 3:10A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947 to Mar 1948
and that I last saw h[illegible] alive on Mar 1 1948

Immediate cause of death	Duration
Acute Cardiac Failure	
Due to Arteriosclerotic Cardio-Vascular disease	
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. B. Stevens M. D.
Address 3400 Erdman Ave Date signed 3/9/48

PLEASE WRITE PLAINLY, with UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

VS 150

1057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G61057

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 928 S. Ellwood Ave
(c) Hospital or institution: 1-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 928 S. Ellwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stanley S. Stanislaw Potocki
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Veronika Potocki
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) april 9 1882

8. AGE: Years	Months	Days	If less than one day
65 66	11	-	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation retired Blacksmith
11. Industry or business

FATHER
12. Name Potocki
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Theresa Pinkowski
(b) Address 928 S. Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem. Location German Hill road

18 (a) Funeral director Stephen J. Frakowiak INC
(b) Address 1008 S. Kenwood Ave

19 (a) Date received by registrar 3-10 1948 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1948 at 3:45 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from April 1946 to March 9 1948 and that I last saw h alive on March 9 1948

Immediate cause of death
Acute Cardiac Decompensation — Duration: 1 day.
Due to Chronic Myocarditis — Duration: 5 yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John V. Zeyerbrecher M. D.
Address 1802 Eastern Ave Date signed 3/10/48

VS. 150

X

1058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G61058

PLEASE WRITE PLAINLY, with unfading ink. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Herring Run Lane & Harford Rd
(c) Hospital or institution: Lyndenhurst Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore Co.
(c) City or town Timonium (If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Howard
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 Jan 48

8. AGE: Years | Months 1 | Days 18 | If less than one day 0 hr. min

9. Birthplace Timonium, Balto. County Maryland (Town, county, and state)

10. Usual Occupation infant

11. Industry or business

FATHER 12. Name Samuel F. Howard
13. Birthplace Cockeysville, Maryland

MOTHER 14. Maiden Name Ella McCleary
15. Birthplace Cockeysville, Maryland

16 (a) Informant Samuel F. Howard
(b) Address Towson RFD. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 12 48 (month) (day) (year)
(c) Cemetery or crematory Poplar Grove
Location Cockeysville

18 (a) Funeral director Talbot & Brooks
(b) Address Towson, Md.

19 MAR 10 1948 (Registered by registrar) (b) Registrar Washington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1948, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 25 1948 to March 9 1948, and that I last saw her alive on March 9 1948

Immediate cause of death respiratory obstruction — Duration

Due to pertussis

Due to

Other Conditions Tracheotomy

(Include pregnancy within 3 months of death)

Date of operation Feb 25, 1948

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Watson Chesnutt Jr.
Address Lyndenhurst Hosp. Date signed 3-9-48

V S 150

G61059

BC-48-05725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1604

G61059

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Sinai Hospital

(c) Hospital or institution: Broadway & Rutland Ave 8-03

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 848 1/2 W. Lombard St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Girl Bartasavich

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ✓

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9th 48

8. AGE: Years | Months | Days | If less than one day 2½ hr. 3 min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER

12. Name Max Bartasavich

13. Birthplace Baltimore Md.

MOTHER

14. Maiden Name Nellie Konczis

15. Birthplace Rochester N.Y.

16 (a) Informant Mrs Max Bartasavich

(b) Address 848 1/2 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 (month) 10 (day) 48 (year)

(c) Cemetery or crematory Holy Redeemer Cem.

Location Belair Rd.

18 (a) Funeral director John J. Cowan & Son

(b) Address 900-03 Walbrook Ave.

MAR 10 1948

(a) (b) Huntington Williams, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/9 1948, at 7.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/9 1948, to 3/9 1948.

and that I last saw h[illegible] alive on 3/9 19 48

Immediate cause of death	Duration
Sudden Failure	
Due to Cerebral hemorrhage	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

TENTORIAL TEAR

of autopsy: Terminal

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature E. Goldstein M. D.

Address Date signed

VS 190

Physicians: please write the cause of death in such a manner that correct age is especially important.

G61060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45F

Registered No. G61060

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. AGNES HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 DAY
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTO.
(c) City or town HALETHORPE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4628 MAGNOLIA AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Bishop

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife BERTHA H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 20, 1894

8. AGE: Years	Months	Days	If less than one day
54	0	18	hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)
10. Usual Occupation CLERK - CIRCUIT COURT
11. Industry or business BALTIMORE Co.

FATHER
12. Name Wm. H. Bishop
13. Birthplace BALTIMORE, MD

MOTHER
14. Maiden Name ELIZABETH WAHL
15. Birthplace BALTO. MD.

16 (a) Informant MRS BERTHA H. BISHOP
(b) Address 4628 MAGNOLIA AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/12/48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location BALTIMORE, MD

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTIMORE, MD.

19 (a) MAR 10 1948 (b)
(Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 Mar 1948 at 8.25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 Mar 1948 to 8 Mar 1948 and that I last saw him alive on 8 Mar 1948

Immediate cause of death	Duration
Generalized Carcinomatosis	
Due to	
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. R. Graf M.D.
M. D.
Address St Agnes Hosp Date signed 8 Mar 48

VS 150

PLEASE WRITE PLAINLY. Physicians: please write the causes of death in terms which will correct age is especially important.

G61061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G61061 Registered No. 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 205 W. MADISON ST.
(c) Hospital or institution: 11-03
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 W. MADISON ST.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Jeremiah J. O'Donovan

3 (b) If veteran, name war: SPANISH

3 (c) Social Security Account No. —

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 26, 1876

8. AGE: Years 71 | Months 2 | Days 14 | If less than one day: 5 hr. min.

9. Birthplace BALTIMORE, MD
(Town, county, and state)

10. Usual Occupation STATIONERY

11. Industry or business SELF

FATHER
12. Name JOHN H. O'DONOVAN
13. Birthplace IRELAND

MOTHER
14. Maiden Name MARGARET O'BRIEN
15. Birthplace IRELAND

16 (a) Informant MR. JAMES E. O'DONOVAN
(b) Address 221 PARK AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/12/48 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location BALTIMORE MD.

18 (a) Funeral director Wm. F. Tietjen & Sons
(b) Address BALTIMORE MD.

MAR 10 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 March 1948, 8:45 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. K. Kammer, Jr. M.D. Medical Examiner.
Date signed 9 Mar. 1948

I certify that the above information is correct as far as is known. Physicians: please write plainly; accuracy is especially important.

VS 151

X

G61062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G61062

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4023 Frankford Ave.
(c) Hospital or institution: 27-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4101 Frankford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LENA HOFSTETTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife George Hofstetter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1862

8. AGE: Years	Months	Days	If less than one day
85	4	15/17	hr. min.

9. Birthplace Baltimore County, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Charles Dollinger
13. Birthplace Germany

MOTHER
14. Maiden Name Lena
15. Birthplace Germany

16 (a) Informant Mr. G. Elmer Hofstetter
(b) Address 4023 Frankford Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 3/12/48 (month) (day) (year)
(c) Cemetery or crematory Jerusalem
Location Baltimore, Md.

18 (a) Funeral director Lazarak Funeral Home
(b) Address 7401 Belair Rd.

19 MAR 10 1948 (Date received by Registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9th 1948, at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 19 1948 to Mar. 9, 1948 and that I last saw her alive on Mar. 8, 1948

Immediate cause of death	Duration
Carcinoma of the uterus (fundus uteri)	3 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Wilkinson
A. L. Wilkinson M. D.
Address 5713 Belair Rd. Date signed 3-9-48

VS 150

PLEASE WRITE PLAINLY, with unfading ink. Be sure to give correct age in each case. Physicians: please write the causes of death clearly and legibly. Information is especially important.

G61063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No. G61063

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 535 Beaumont ave
(c) Hospital or institution: 27-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 535 Beaumont ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph A. Farrell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/11/1875

8. AGE: Years	Months	Days	If less than one day
72	8	27	hr. min.

9. Birthplace Baltimore Co. Md. (Town, county, and state)
10. Usual Occupation Manager
11. Industry or business Barrel Box Truck

FATHER
12. Name John Farrell
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Roche
15. Birthplace Ireland

16 (a) Informant Mr Ezra Farrell
(b) Address 535 Beaumont ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/48 (month) (day) (year)
(c) Cemetery or crematory St Marys Seminary
Location Homeland Park

18 (a) Funeral director J. J. Fahey Sons
(b) Address 1218 Light St.

MAR 10 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 March 1948, at 4:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to 8 Mar 1948, and that I last saw him alive on 8 Mar 1948.

Immediate cause of death Acute myocardial failure — Duration

Due to Carcinoma of prostate with metastases to lungs — 4 years

Due to and other internal organs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. E. Muse Jr.
Address 3311 St Paul St Date signed 8 Mar 48
Balto. 18 Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

C61064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

C61064 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp. C 1
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3020 Elliott St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country — — —

3 (a) FULL NAME Frederick A. Thomas

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife None.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 24. 1889

8. AGE: Years	Months	Days	If less than one day
58	6	15	16 hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Marine Engineer
11. Industry or business

FATHER
12. Name Harry Thomas
13. Birthplace Balto.

MOTHER
14. Maiden Name Laura Jones
15. Birthplace Balto.

16 (a) Informant Ida May Mickinson
(b) Address 3020 Elliot St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-48 (month) (day) (year)
(c) Cemetery or crematory Dale Lawn
Location Eastern Ave East.

18 (a) Funeral director Lilley & Leiby Inc
(b) Address 403 S. Wolfe St. 31

19 (a) MAR (Date rec'd by registrar) (Quentington Williams) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1948 at 8 40 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to hanging

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-9-48 at 8 AM (?)
(b) Where did injury occur? 1700 Block Bank St. & Christian St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Hanging Suicide by rope

23. Signature [signature] M.D.
Medical Examiner.
Date signed 3-9-48

correct age is especially important. If unknown, please write

VS 181

G61065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G61065 / 1318

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 12-03
(d) Length of stay in hospital or inst. (yrs., mos., or days) three
(e) Length of stay in Baltimore (yrs., mos., or days) 25

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore MD
(If outside city or town limits, write RURAL and give town)
(d) Street No. 502 George St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country None

3 (a) FULL NAME Betty Berry (Bessie [redacted] Collins Dorsey)

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: Fe

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Willie Dorsey

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept 5 1915

8. AGE: Years 32 | Months 6 | Days 3 2 | If less than one day: hr. ____ min.

9. Birthplace Baltimore, MD
(Town, county, and state)

10. Usual Occupation Dresser

11. Industry or business

FATHER
12. Name James Wesley Collins
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mamie Jarvis
15. Birthplace Baltimore, Md.

16 (a) Informant Mamie Collins
(b) Address 502 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 11, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N. Schroeder St

19 MAR 10 1948 (Date rec'd by registrar) (b) Registrar Washington Williams

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/7 1948, at 9:22 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/2 1948, to 3/7 1948, and that I last saw h[illegible] alive on 3/2 1948.

Immediate cause of death: Chronic Glomerulo Nephritis — Duration

Due to: Uremia

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William C. Cassen

Address 1514 Division St Date signed 3/8/48

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and correct age is especially important.

G61066 GEORGE L. WALTERS G61066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 126

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 13-07
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 N 42nd Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George L. Walters

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced	6 (b) Name of husband or wife	6 (c) If alive, give age
—	213-03-2796	Male	White	Married	Georgianna E. Walters	years

7. Birth date of deceased (mo., day, yr.) May 17 1887

8. AGE: Years 60 | Months 9 | Days 23 | If less than one day: hr. min.

9. Birthplace Baltimore Co. Maryland (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Baltimore Sun Paper

FATHER 12. Name	Robert Walters
13. Birthplace	Maryland
MOTHER 14. Maiden Name	Emma Gregg
15. Birthplace	Maryland

16 (a) Informant Harry Walters
(b) Address Hoop Cathedral, Washington D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 13-1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co. Maryland

18 (a) Funeral director Burger Funeral Home
(b) Address 3231 Falls Road

18 (c) MAR 10 1948 (Date rec'd by registrar) (b) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10 1948 at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/28 1948 to 3/10 1948 and that I last saw him alive on 3/10 1948.

Immediate cause of death	Duration
Pulmonary Embolism	
Due to Thrombophlebitis of legs	
Due to Post op bed rest	
Other Conditions H.T. failure	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Cholelithiasis - Gangrene G.B.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature K A Neuhauser, MD M. D.
Address Date signed

correct age is especially important. ✱ typewriter

VS 150

X

G61067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G61067

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1318 N. Belvedere Avenue

(c) Hospital or institution: 27-15

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1318 N. Belvedere Avenue (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Harry Leroy Cook

3 (b) If veteran, name war: World war #1

3 (c) Social Security Account No. 212-05-5707

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22-1893

8. AGE: Years 54 | Months 7 | Days 16 | If less than one day: hr. min.

9. Birthplace Dandy Springs, Maryland (Town, county and state)

10. Usual Occupation Stock Clerk

11. Industry or business Bal-May Corporation

FATHER 12. Name Frank A. Cook

13. Birthplace Wisconsin

MOTHER 14. Maiden Name Lillian E. Gorham

15. Birthplace Virginia

16 (a) Informant Mrs. Lillian E. Cook

(b) Address 1318 N. Belvedere Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 11-1948 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Fpills Road

Signature of Undertaker Williams, M.D.

19 (a) 1948 (Date received by registrar)

Registrar

MAR 10

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8- 1948, at 9:25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to March 8 1948, and that I last saw him alive on March 8 1948.

Immediate cause of death Pulmonary Tbc — Duration 5-6yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Lawrence J. Shimanek M. D.

Address 3711 Falls Rd. Date signed 3-9-48

X SHIMANEK

Correct age is especially important. Physicians: please write the cause of death

Dr. Golly G61068

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G61068 Registered No.

83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Pineridge Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Baltimore Parkville
(a) State Md. (b) County Parkville
(c) City or town Baltimore Parkville (If outside city or town limits, write RURAL and give town)
(d) Street No. 9002 Harford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John E. Kirwan

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1876

8. AGE: Years	Months	Days	If less than one day
71	4	17 19	hr. min.

9. Birthplace Dorchester Co, Md. (Town, county, and state)
10. Usual Occupation Retired Merchant
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Mary M. Kirwan
(b) Address 9002 Harford Road, #14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-11-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, #14

MAR 10 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-3 1948, to 3-9 1948, and that I last saw him alive on 3-7 1948.

Immediate cause of death Hemorrhage, Cerebral — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John T. Schaefer M. D.
Address 5103 Harford Rd. Date signed 3-9-48

VS 150

Funeral Director Washington Boulevard, Md.

(LOCUM TENENS M. Golly)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G61069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G61069 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1609 Bolton St.
(c) Hospital or institution: home 14-01
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town City of Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 Bolton St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME John Scott McEldowney

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 229-14-4430

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louise Cotten McEldowney

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Oct. 9-1866

8. AGE: Years 81 | Months 5 | Days 0 | If less than one day ____hr. ____min.

9. Birthplace Near Ellicott City - Md.
(Town, county, and state)

10. Usual Occupation Retired - Salesman

11. Industry or business Woollens

FATHER
12. Name John McEldowney
13. Birthplace Ireland

MOTHER
14. Maiden Name Mathilda Scott
15. Birthplace Balto. - Balto. - Md.

16 (a) Informant Mrs. Louise C. McEldowney - wife
(b) Address 1609 Bolton St. City - 17

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-11-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore City

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Ave. - Balto. - 1 - Md.

(a) ____ (b) ____
(Date rec'd by registrar)

Funeral for Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 March 1948, at 11:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1925 to 9 March 1948 and that I last saw h[illegible] alive on 9 March 1948

Immediate cause of death: myocardial failure — Duration: ____

Due to: arterio-sclerosis — Duration: ____

Due to: senility — Duration: ____

Other Conditions: none — Duration: ____

(Include pregnancy within three months of death) — Duration: ____

Date of operation: none — Duration: ____

Major findings of operation: — Duration: ____

of autopsy: none — Duration: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at ____ M
(c) Where did injury occur? none
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify home, farm, etc.)
(e) Means of injury —

23. Signature Robert Arnett, M.D.

Address 717 Park Ave. Balto-1, Md. Date signed 9 March 1948

MAR 10 1948

VS 150

X

Correct age is especially important. Physicians, please

G61070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G61070
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 14-01
(d) Length of stay in hospital or inst. (yrs., mos., or days): 12 days
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: Marlborough Apts.
(If rural give location)
Wilson & Eutaw Sts.
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: IDA BRIDGMAN

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 8, 1861

8. AGE: Years	Months	Days	If less than one day
87	1	2	hr. min.

9. Birthplace: Balto, Md.
(Town, county, and state)
10. Usual Occupation: None
11. Industry or business:

FATHER
12. Name: John Pickrell
13. Birthplace: Va.

MOTHER
14. Maiden Name: Violetta Sprigg
15 Birthplace: Balto, Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-11-48 (month) (day) (year)
(c) Cemetery or crematory: Green Mount
Location: Baltimore
18 (a) Funeral director: Stewart Mortuary
(b) Address: 138 W. North Ave.
19 (a) (Date rec'd by registrar) MAR 10 1948 (b) Registrar

vs 155

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10 1948, at 1:15A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 27 1948 to Mar. 10 1948, and that I last saw him alive on Mar. 10 1948.

Immediate cause of death: Senility
Arteriosclerosis general
Due to: Bronchopneumonia due to undetermined cause (terminal)
Due to: Acute parotitis (terminal)
(duo)
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: None done

Duration: UNKNOWN

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon
Address: Clinical Director Date signed: 3/10/48 M. D.

PLEASE WRITE PLAINLY. Be sure to correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G61071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G61071 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town [redacted] Elkridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. Stony Run Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME Rosina Catherine Arnold

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife John Arnold

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5, 1873

8. AGE: Years 75 | Months 2 | Days 3 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name John Zinkel
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara ?
15. Birthplace Germany

16 (a) Informant John M. Arnold
(b) Address Meadow Ridge Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 11-1948 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave

19 (a) [illegible] (b) Huntington Ave

MAR 10 1948

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1948, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 26 1948 to Mar. 8 1948 and that I last saw her alive on Mar. 8 1948

Immediate cause of death: Congestive failure — Duration: 9

Due to Arteriosclerotic hypertensive C.V.D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert J. Luecken
Address St. Agnes Hosp. Date signed 3/9/48

X

correct age is especially important. Physicians, please

G61072

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 124a

G61072 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Agnes Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1322 W Lexington St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Benzinger

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-18-9448

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1900

8. AGE: Years 47 | Months 5 | Days 23 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Elevator Operator

11. Industry or business Paper Box Factory

FATHER
12. Name Edward A. Benzinger
13. Birthplace Maryland

MOTHER
14. Maiden Name L. Gertrude Bleary
15. Birthplace Maryland

16 (a) Informant Mrs Rose Benzinger
(b) Address 101 Tongston St Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 11, 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md

18 (a) Funeral director Easton Sons
(b) Address Ellicott City, Md

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

MAR 10 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 9 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 7 1948 to Mar 9 1948, and that I last saw h— alive on Mar 9 1948

Immediate cause of death Cardiac failure
Cerebral edema
Due to Acute & chronic
Due to Alcoholism
Fatty liver
Other Conditions Lung abcess
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sidney D. Jewett Jr. M.D.
Address St Agnes Hospital Date signed 3-9-48

X

661073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 661073

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Franklin Square Hosp
(c) Hospital or institution: Calhoun & Fayette St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 103 S. Schroeder St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter J. Arrington

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Nettie E.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 11th 1900

8. AGE: Years	Months	Days	If less than one day
47	4	28	hr. min.

9. Birthplace Easton Md. (Town, county, and state)
10. Usual Occupation Manager
11. Industry or business Canteen

FATHER
12. Name Walter J Arrington
13. Birthplace Md.

MOTHER
14. Maiden Name Lillie Marshall
15. Birthplace Md.

16 (a) Informant Mrs. Nettie E. Arrington
(b) Address 103 S. Schroeder St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 (month) 13 (day) 48 (year)
(c) Cemetery or crematory Sharp Hill Cem
Location Easton Md

18 (a) Funeral director John J. Cowan & Son
(b) Address 201-03 Hollins St.

MAR 11 1948 (Date rec'd by registrar) Washington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10th 1948 at 12 Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 18 1948 to Feb. 20 1948, and that I last saw h— alive on Feb. 20 1948.

Immediate cause of death	Duration
Acute Coronary Occlusion	months
Due to Arteriosclerotic heart disease	years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Tammaccello M. D.
Address 9 W. Lombard St Date signed 10 Mar 1948

PLEASE WRITE PLAINLY, with ordinary pen and ink. Do not use pencil. Do not fold. Do not roll. Use typewriter if possible. Physicians: please write the causes of death clearly and correct age is especially important.

VS 150

X

1948 -

661074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 661074

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1920 Christian St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1920 Christian St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret A. Dickinson

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Harry J.
6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) March 2nd 1885

8. AGE: Years	Months	Days	If less than one day
63		7	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation House Work
11. Industry or business at Home

FATHER
12. Name John Schoefer
13. Birthplace Germany

MOTHER
14. Maiden Name Sophie Spies
15. Birthplace Germany

16 (a) Informant Mrs Lilliand C. Fish
(b) Address 1920 Christian St

17 (a) Burial (b) Date thereof 3/13/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location 3801 Frederick Ave

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins St

19 (a) MAR 11 1948 (b)
(Date rec'd by reg.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9th 1948, at 8.57 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1940 to March 9 1948
and that I last saw h alive on 19

Immediate cause of death: Hypostatic pneumonia Contributory disease — Duration 7 days

Due to

Due to

Other Conditions Cerebral Thrombosis — 7 days
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert H Katz M.D.
Address 2030 Wilkens Ave Date signed 3/19/48

PLEASE WRITE PLAINLY, with ink. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G61075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G61075

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2724 N. Charles St.
(c) Hospital or institution: Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A A Co.
(c) City or town Severna Park (If outside city or town limits, write RURAL and give town)
(d) Street No. Cypress Gate Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adam G Saltzmann

3 (b) If veteran, name war –

3 (c) Social Security Account No. ✓

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Margaret D.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16th 1883

8. AGE: Years 64 | Months 10 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Upholstering

11. Industry or business Self

FATHER
12. Name George Saltzmann
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary C. Trulief
15. Birthplace Baltimore Md.

16 (a) Informant Mr. George Saltzmann
(b) Address Severna Park

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn Md.

18 (a) Funeral director John J. Cowan & Son
(b) Address 7203 Hollins St.

19 (a) MAR 11 1948 (Date rec'd by Registrar) (b) Washington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1948, at 11:13 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/29 1948 to 3/9 1948.
and that I last saw him alive on 3/9 1948.

Immediate cause of death	Duration
Bronchopneumonia	1 day
Due to cerebral hemorrhage	12 days
Due to Hypertension, arteriosclerosis	20 yrs 10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lester J. Lord M. D.
Address 2200 N. Charles St. Date signed 3/10/48

correct age is especially important. Physicians please

VS 139

61076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 66076

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St
(c) Hospital or institution: Good Samaritan Home 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town 39 of Main Ave. Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie L. Whitby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Widowed

6 (b) Name of husband or wife Wm N. Whitby
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 19, 1859

8. AGE: Years	Months	Days	If less than one day
89	0	10	hr. min.

9. Birthplace Caroline County, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Cyrus Lane
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Crafton
15. Birthplace Md.

16 (a) Informant Dwight E. Russell, Jr.
(b) Address 3904 Maine Avenue, Baltimore Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 5, 1948 (month) (day) (year)
(c) Cemetery or crematory Wrightsville
Location Easton Md.

18 (a) Funeral director Miles Clark.
(b) Address Easton Md.

19 (a) 3/5/48 (Date rec'd by registrar) (b) N. D. Pearce Registrar

MAR 11 1948 Certificate No. 11750

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1948, at 5:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1948 to March 2 1948, and that I last saw her alive on March 2 1948.

Immediate cause of death	Duration
Cerebral accident	?
Due to congestive Heart failure	?
Due to Hypertension and Cerebrovascular Disease	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Helen Lafrocia M. D.
Address 27 North Carey St. Date signed March 4 1948

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and report correct age is especially important.

X

G61077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G61077

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5709 BELLONA AVE
(c) Hospital or institution: 27
ABOVE ADDRESS
(d) Length of stay in ~~hospital or inst.~~ (yrs., mos., or days) 7½ YRS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5709 BELLONA AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES ROBERT WATSON

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
NO	YES	M	W	MARRIED

6 (b) Name of husband or wife GRACE M
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 10, 1881

8. AGE: Years	Months	Days	If less than one day
66	9	29	hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)
10. Usual Occupation CASHIER
11. Industry or business BALTO. TRANSIT CO.

FATHER
12. Name CHARLES R. WATSON
13. Birthplace MD.

MOTHER
14. Maiden Name KATHERINE WATERS
15. Birthplace MD.

16 (a) Informant MRS. GRACE M. WATSON
(b) Address 5709 BELLONA AVE

17 (a) BURIAL (b) Date thereof 3/11/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ WOODLAWN
Location BALTO. CO., MD.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address BALTIMORE, MD

19 (a) MAR 11 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/9/48, 19 12 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 9 1948 to Mar. 9 1948 and that I last saw him alive on Mar. 8 1948

	Duration
Immediate cause of death: Uremia	11 Days
Due to: Chronic Interstitial Nephritis	2 months.
Due to:	
Other Conditions: Cerebral Hemorrhage	2 months.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of ~~accident~~)
(e) Means of injury

23. Signature Karl H. Beusan, M.D.
Address 511 York Rd. Date signed 3/9/48 M.D.

VS 190

correct age is especially important. Typewriter [illegible]

661078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 661078

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 PARK AVE
(c) Hospital or institution: WHEELER NURSING HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Montgomery
(c) City or town SILVER SPRING
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 GRACE CHURCH RD
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME HELEN ELIZABETH IJAMS

3 (b) If veteran, name war NO | 3 (c) Social Security Account No. NO

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced WIDOWED

6 (b) Name of husband or wife DR. GEO. EDGAR IJAMS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 14 1861

8. AGE: Years 86 | Months 7 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace FINKSBURG, MD.
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name JAMES WARREN JORDON
13. Birthplace CARROLL CO., MD.

MOTHER
14. Maiden Name UNKNOWN
15 Birthplace

16. (a) Informant MR. GEO. E. IJAMS - SON
(b) Address 1508 GRACE CHURCH RD.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/12/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ LOUDON PK
Location BALTIMORE, MD.

18. (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTIMORE, MD.

19. (a) MAR 11 1948 (Date rec'd by registrar) (b) Huntington Williamsville, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 10, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1 1946, to 3-10-1948, and that I last saw h[illegible] alive on 3-10 1948.

Immediate cause of death — Duration

Myocardial weakening — 3 mo.

Due to —

Due to Arteriosclerosis — - -

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Howard H. Warren M. D.
Address 2604 Garrison Rd Date signed 3-11-48.

correct age if possible, supplying the information

VS 150

661079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 661079

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2604 E. FAYETTE ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 - 3
(e) Length of stay in Baltimore (yrs., mos., or days) 30 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2604 E. FAYETTE ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ETTA ELIZABETH BUCKMASTER

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife: CHARLES E
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 19, 1876

8. AGE: Years	Months	Days	If less than one day
71	2	21	hr. min.

9. Birthplace: CALVERT CO., MD. (Town, county, and state)
10. Usual Occupation: HOUSEWIFE
11. Industry or business: @ HOME

FATHER
12. Name: JOHN WARD
13. Birthplace: CALVERT CO., MD.

MOTHER
14. Maiden Name: ANNE MILLS
15. Birthplace: CALVERT CO., MD.

16 (a) Informant: EVERETT L. BUCKMASTER
(b) Address: 5726 OFFINGTON RD.

17 (a) BURIAL (b) Date thereof 3/12/48 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory: CHRIST EPISCOPAL
Location: PORT REPUBLIC, CALVERT CO. MD.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: BALTO., MD.

19 MAR 11 1948 (Date rec'd by registrar) (b) Registrar: Livingston Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10 1948, at 4.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from OCT 12 1935 to 3/10 1948 and that I last saw h[illegible] alive on 3/9 1948.

	Duration
Immediate cause of death: Cardiac Arrhythmia	1 wk
Due to: Chronic arthritis	12 yrs
Due to:	
Other Conditions: arteriosclerosis	5 yrs

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: J. F. Strawbridge M. D.
Address 88 39th St Date signed 3/4/48

correct age if apparently incorrect

VS 190

X

61080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 80a

Registered No. 061080

GH. 115332

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 2-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Months
(e) Length of stay in Baltimore (yrs., mos., or days) 11 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 236 S. Durham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June. 16-1890

8. AGE: Years	Months	Days	If less than one day
57	8	24	hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Mary Reed
15. Birthplace N.C.

16 (a) Informant Records B lto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 3-13-48 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Balto

18 (a) Funeral director Samuel W. Sullivan Jr.
(b) Address 1011 N. Arlington Ave

19 MAR 11 1948 (Date rec'd by Registrar) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 10 - 1948, at 2.03A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11- 18- 1947, to 3 - 10 - 1948, and that I last saw him alive on 3 - 10 -1948.

Immediate cause of death	Duration
Multiple Abscesses of Brain	
Due to	
Due to	
Other Conditions Bronchopneumonia; Pulmonary Edema (Include pregnancy within 3 months of death)	

Date of operation 11/26/47

Major findings of operation: Empyema, abscess, left parietal

of autopsy: as above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank S. Turner M. D.
Address Baltimore City Hosp. Date signed 3/11/48

VS 199

Please write clearly. Physicians: please write the cause of death in such a way that the correct age is especially important.

G61081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G61081

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 26
(c) Hospital or institution: Snyder Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3401 Mayfield Ave (If rural, give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME MARY ZORBACH

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24-1890

8. AGE: Years	Months	Days	If less than one day
57	7	14	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Anton Petry
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Rosmer
15. Birthplace

16 (a) Informant Geo Zorbach
(b) Address 3401 Mayfield Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-11-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto
18 (a) Funeral director J. A. J. Waters & Son
(b) Address 3001 Kentucky Ave
19 (a) MAR 11 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1948, at 4:50 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 1945 to 3/9 1948. and that I last saw her alive on 3/9 1948.

Immediate cause of death	Duration
Cerebral haemorrhage	48 hrs
Due to Hypertensive cardio-vascular disease	2 yrs
Due to	
Other Conditions Diabetes mellitus	15 Yrs

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harvey L. Fuller M. D.
Address Ridge Rd, Balt-6 Date signed 3/9/48

VS 2

93

61082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 133a

Registered No. 61082

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 - 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4510 Hamphrey Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** [illegible] Caroline McClelland.

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex: F
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: ~~Single~~ Widow
6 (b) Name of husband or wife: Geo. W. McClelland
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Dec. 3, 1859
8. AGE: Years 88 | Months 3 | Days 7 | If less than one day ____ hr. ____ min.
9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: none
11. Industry or business

MOTHER / FATHER
12. Name: John H. Schneider
13. Birthplace: Germany
14. Maiden Name: Hedwig Woehler
15. Birthplace: Germany

16 (a) Informant: Miss Laura Schneider
(b) Address: 532 E. 33rd. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 13/48 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cem.
Location: Balto. Md.

18 (a) Funeral director: Philip Herwig Sons
(b) Address: 2024 Orleans St.

19 (a) MAR 11 1948 (Date rec'd by registrar) Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10 1948 at 6:19 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1948 to March 10 1948 and that I last saw her alive on March 10 1948

Immediate cause of death: Toxemia + eclampsia — Duration
Due to: Pyelonephritis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: None

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: John F. Bonan M.D. M. D.
Address: Univ. Hospital Date signed 9/10/48

Correct age if especially any

VS 150

X

G61083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G61083

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17 S.Linwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-2
(e) Length of stay in Baltimore (yrs., mos., or days) 65yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 17 S.Linwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Marshall Childs

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Etta H.Childs
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug.22,1879
8. AGE: Years 68 | Months 6 | Days 17 | If less than one day hr. min.
9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Chas.W.Childs
13. Birthplace ---

MOTHER
14. Maiden Name Catherine
15. Birthplace Ohio

16 (a) Informant Mrs.Etta H.Childs
(b) Address 17 S.Linwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March.13/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto. Md.

18 (a) Funeral director Philip Herring & Sons
(b) Address 2024 Orleans St.

19 (a) MAR 11 1948 (Date rec'd by registrar) (b) Huntington Whitis (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9th 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1948 to March 9 1948, and that I last saw h[illegible] alive on March 2 1948.

	Duration
Immediate cause of death: Acute Cardiac Dilatation	1½ hr
Due to: Chr. Cardio Vascular Dis. with Decompensation	6 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Michael A Shane M.D.
Address 1870 Eutaw Place Date signed March 10/48

M. D.

V S 150

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and fully. correct age is especially important.

61084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 131a

Registered No. G61084

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4601 Pall Mall Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-12
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2473 Shurley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dora Rosenthal

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Sam

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Louis
13. Birthplace Russia

MOTHER
14. Maiden Name Mendel
15. Birthplace Russia

16 (a) Informant Sam Rosenthal
(b) Address 2473 Shurley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-12-48 (month) (day) (year)
(c) Cemetery or crematory Mishkan Israel
Location Southern Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2106 Eutaw Place

(a) MAR 11 1948 (Date rec'd by registrar) (b) Thurlington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-11-1948 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 19 to March 5 1948 and that I last saw her alive on March 5 1948.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Hypertensive C.V.D.	
Due to Arteriosclerosis, Auricular fibrillation	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Morris A. Fine M. D.
Address 118 Biscayne Rd Date signed 3/11/48

150

61085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 61085

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 813 So Ellwood ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 24.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 813 So Ellwood ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin Kendzierski

3 (b) If veteran, name war	3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of ~~husband~~ wife Prakseda
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Nov 8 1865?

8. AGE: Years	Months	Days	If less than one day
82-83?	4	7	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Retired Farmer.
11. Industry or business B & O R R

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Mrs Eva Mrozinski
(b) Address 813 So Ellwood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-48. (month) (day) (year)
(c) Cemetery ~~crematory~~ St Stanislaus
Location Baltimore Md

18 (a) Funeral director Geo E L Weber
(b) Address 705 S. Linn st

19 (a) MAR 11 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9th 1948, at 9:20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 25 1947 to Mar 9 1948, and that I last saw him alive on Mar 9 1948

Immediate cause of death	Duration
Arteriosclerotic C.V. Disease.	
Chr. Myocarditis.	
Due to Bronchial Pneumonia.	
Due to Myocardial Failure	2-25-47
Other Conditions None. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. A. Schmunk
Address 1428 E. 33rd St Date signed 3-9-48 M. D.

VS 3

X

G1086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 169

G61086

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~Bethlehem Steel Yard~~,
(c) Hospital or institution: Bethlehem Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1434 Angleseas St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter J. (Kinstler) C. Kinstler

3 (b) If veteran, name war WW2.

3 (c) Social Security Account No. 214-18-5521

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife Single

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1919

8. AGE: Years 28 | Months 3 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Frederick C. Kinstler
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Anna Tirschmann
15. Birthplace Unknown

16 (a) Informant Frederick C. Kinstler
(b) Address 1434 Angleseas St.

17 (a) Burial (b) Date thereof 3-12-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~cemetery~~ St Mark's
Location Baltimore Md.

18 (a) Funeral director George A Weber
(b) Address 705 So Clinton st

19 (a) MAR 11 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1948, at 6:20 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed chest.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 9/48 6:20 P. M.
(b) Where did injury occur? Bethlehem Steel Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial Bethlehem While at work? Yes
(d) Means of injury Crushed between two ~~Freight Cars~~.

23. Signature [signature] M.D.
Medical Examiner.
Date signed 3-10-49

VS 191

X

61087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 61087

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 34-S. Catherine St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 4
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 34-S. Catherine St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGIANNA HAUPT.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed.

6 (b) Name of husband or wife Henry Haupt.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8-1864

8. AGE: Years	Months	Days	If less than one day
83	3	1	hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual Occupation Retired -
11. Industry or business - House Wife.

FATHER
12. Name Isaac Jones
13. Birthplace Penna.

MOTHER
14. Maiden Name Eliza Cushion.
15. Birthplace Carroll Co. Md.

16 (a) Informant Walter H. Haupt.
(b) Address 34-S. Catherine St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof March 12/48. (month) (day) (year)
(c) Cemetery or crematory London Park Cemetery.
Location Baltimore - Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 3512 - Fredderick, Ave.

19 MAR 11 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March, 9th: 1948, at 4.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 Mar 1948, to 9 Mar 1948. and that I last saw her alive on 9 Mar 1948

Immediate cause of death Bronchopneumonia — Duration 8 days

Due to Pulmonary Edema

Due to Myocardial Disease

Due to Arteriosclerosis Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Baylus M. D.
Address 1600 Wilkens Ave. Date signed 11 March 48

V S 130

PLEASE WRITE PLAINLY. Physicians: please write the cause of death clearly and give correct age is especially important.

51088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 144a

Registered No. G61088

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Roland & Greene Sts
(c) Hospital or institution: University Md. Hospital 19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1/2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 234 North Gilmore St. Bsmt #23
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** MARY ANN CARTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1928

8. AGE: Years	Months	Days	If less than one day
20			hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation COOK

11. Industry or business

FATHER
12. Name James Jackson
13. Birthplace

MOTHER
14. Maiden Name Elizabeth Johnson
15. Birthplace

16 (a) Informant Mother
(b) Address 234 North Gilmore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo H. Kelson
(b) Address 1303 Presstman St

19 MAR 11 1948 (Date rec'd by registrar) (b) Huntington Williamsville, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1948 at 6:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-9 1948 to 3-10 1948
and that I last saw her alive on 3-10 1948.

Immediate cause of death	Duration
Shock —	
Toxemia	
Due to Eclampsia	
Due to Pregnancy 25 wks. not delivered	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation No Operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
(f) Signature Wm. C. Cary, M.D.
Address University Md. Hosp. Date signed 3-10-48

correct age if obviously improper

VS 153

G61089

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a

G61089 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2702 Tivoly Avenue
(c) Hospital or institution:

9-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2702 Tivoly Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILEY HUNT GELBACH

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
NO	NONE	M	W	Married

6 (b) Name of husband or wife Mary E. Gelbach
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) October 31, 1870

8. AGE: Years	Months	Days	If less than one day
77	4	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business Ft. Howard

FATHER
12. Name John Gelbach
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Susan Hunt
15 Birthplace Baltimore, Md.

16 (a) Informant Mrs. Mary E. Gelbach
(b) Address 2702 Tivoly Avenue

17 (a) Burial (b) Date thereof 3/11/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY
Huntington Williams, M.D.

MAR 11 1948 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1948 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1946 to Mar 1948, and that I last saw him alive on 8 Mar. 1948.

Immediate cause of death	Duration
Heart Failure	3 years
Due to Arteriosclerotic Cardio-Vascular renal disease	10 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Loy M Zeimer
Address 2554 Harford Rd Date signed 9 Mar. 48 M. D.

VS 150

X

Correct age is especially important. Physicians, please write plainly.

In Water G61090 Lawry G61090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 93

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 728 Penn. ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 728 Penn. ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lavinia Lawry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Rubain Henderson

13. Birthplace Md

MOTHER 14. Maiden Name Lettie Platt

15. Birthplace Md

16 (a) Informant Lavinia Gordon

(b) Address 728 Penn. ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 10-19 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem

Location Baltimore Md

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Bentley ave

19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

3-4-48

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1948 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 3 1948 to March 7 1948 and that I last saw h[illegible] alive on March 7 1948

Immediate cause of death	Duration
Bronchopneumonia	4 days
Due to	
Due to Disease	
Other Conditions Cardiac Decompensation (Include pregnancy within 3 months of death)	1 3/12 years

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. W. D. Wilson M. D.

Address [illegible] Date signed 3/10/48

MAR 11 19[illegible]

VS 150

107

correct age is especially important. If uncertain, say so.

H.Z.H.C

G61091

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G61091 Registered No. A61005

1577

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore County (If outside city or town limits, write RURAL and give town)
(d) Street No. 510 Collar Way Farmer's Station Balto Co (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Baby Cynthia Cole
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 2/25/48

8. AGE: Years	Months	Days	If less than one day
X		13	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name James Cole
13. Birthplace Va
14. Maiden Name Isabella ?
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 11 '48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem. Location a.a. County Md
18 (a) Funeral director Mrs Bott & Chas. Ott
(b) Address 1129 N. Caroline St.
19 (a) (Date received by registrar) (b) Registrar

MAR 11 1948 Kensington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/9 1948, at 450 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 2/25 1948 to 3/9 1948 and that I last saw her alive on 3/9 1948.

Immediate cause of death: Encephalocoele — Duration 13 D.
Due to: Congenital Malformation
Due to:
Other Conditions: Epicolic Septicemia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [illegible]
Address Johns Hopkins Hosp Date signed 3/11/48

Correct age is supplied

G61092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G61092
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 C Monument St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Emma
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) 5-9-94

8. AGE: Years 53 | Months 10 | Days - | If less than one day hr. min.

9. Birthplace Maryland (Town, county and state)

10. Usual Occupation Janitor

11. Industry or business

MOTHER / FATHER
12. Name Abe Parker
13. Birthplace Md
14. Maiden Name Emma Hooper
15. Birthplace Md

16 (a) Informant Emma Carr
(b) Address 1008 E. Monument St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 11th (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A A County

18 (a) Funeral director Mrs Ruth A. Elliott & Son
(b) Address 1129 N. Carey St

19 (a) 1948 (Date received by registrar) (b) Registrar

MAR 10 1948 Washington Co. Md. Registrar

VS 150

correct age is especially important. 2 physicians please

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1948, at 10 20A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-22- 1948 to 3-9- 1948 and that I last saw him alive on 3-9 1948

Immediate cause of death UREMIA — Duration

Due to CHRONIC GLOMERULO NEPHRITIS

Due to

Other Conditions DIABETES MELLITUS ABSCESS OF LEG ARM AT THIGH
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank de J Hopkins
Address Johns Hopkins Hosp Date signed 3/9/48

131B

G61093

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G61093 Registered No. 181

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun St
(c) Hospital or institution: Franklin Sq Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 328 N. Gilmore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Lee Feaster

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Col.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 14 - 1944

8. AGE: Years	Months	Days	If less than one day
3	5	24	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Feaster, John
13. Birthplace S.C.

MOTHER
14. Maiden Name Nancy Stevenson
15. Birthplace S.C.

16 (a) Informant Nancy Feaster - Mother
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 11, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 Hamilton Ave St Williamsport, Md

19 (a) MAR 1 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 8 1948, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 3 1948, to Mar 8 1948, and that I last saw her alive on Mar 8 1948

Immediate cause of death	Duration
2nd & 3rd degree Burns of entire body	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 19(1)
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Mar 3, 1948 at 12 noon PM
(c) Where did injury occur? Balt. (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? —
(e) Means of injury Dress caught fire from stove

23. Signature A. J. Lahaman M. D.
Address Franklin Sq Hosp Date signed 8 Mar 48

Homer L. Mueller, M.D.

VS 150

PLEASE WRITE PLAINLY. Correct age is especially important. Physicians: please write the cause of death clearly and accurately.

C61094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

C61094 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1106 N. Carey St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Edgar Ford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col	Married

6 (b) Name of husband or wife Emma V. Ford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13 1868

8. AGE: Years	Months	Days	If less than one day
78	6	26	hr. min.

9. Birthplace Washington D.C.
(Town, county and state)

10. Usual Occupation Minister

11. Industry or business

FATHER
12. Name Robert Ford
13. Birthplace Culpeper Va.

MOTHER
14. Maiden Name Gabriel
15. Birthplace Culpeper Va.

16 (a) Informant Emma Ford
(b) Address 1106 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 12 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) (b) Washington Williams Registrar
(Date received by registrar)

MAR 11 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1948 at 6:32 M

21. I certify that death occurred on the date above stated, that I attended deceased from June 5 1947 to March 8 1948, and that I last saw him alive on March 8 1948

Immediate cause of death: Myocarditis Arteriosclerosis Uremia — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bernard Harris M. D.
Address 920 N. Carey St Date signed 3/10/48

Correct age is especially important. Physicians: please write the cause of death plainly.

G61095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G61095 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1162 Shields Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1162 Shields Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Ringgold Morgan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col.	Married

6 (b) Name of husband or wife Wilson Morgan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6 1905

8. AGE: Years	Months	Days	If less than one day
47	9	2	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Ringgold
13. Birthplace Md.

MOTHER
14. Maiden Name Annie ?
15. Birthplace Md.

16 (a) Informant Wilson Morgan
(b) Address 1162 Shields Pl.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 12 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-7 1948 to 3-9 1948 and that I last saw h[illegible] alive on 3-8 1948

Immediate cause of death	Duration
Cardiovascular Vascular Disease	1 yr
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W Atwell Jones M. D.
Address 5-5-4 Dolphin St Date signed 3-10-48

Correct age is especially important. Physicians: please write the cause of death plainly.

VS 150

061096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

33a

Registered No. 061096

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Leadenhall St
(c) Hospital or institution: no
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Co. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Leadenhall St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Fletcher Foster

3 (b) If veteran, name war no

3 (c) Social Security Account No. no

4. Sex male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 52 yrs | Months — | Days — | If less than one day — hr. — min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name George Foster
13. Birthplace md

MOTHER
14. Maiden Name Annie Smith
15. Birthplace md

16 (a) Informant Grainshaw Douglass
(b) Address 901 Leadenhall St

17 (a) Burial (b) Date thereof 3/11/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.A. Co Md

18 (a) Funeral director Isaiah L Brown Son
(b) Address 1046 Monty omery St

19 (a) MAR 11 1948
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6" 1948 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1" 1948 to Mar. 6 1948.
and that I last saw h alive on 19

Immediate cause of death
Acute Broncho-pneumonia — Duration 18 days
Due to
Due to Influenza — 16 days
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Lindsay Shelton M.D.
Address 901 S. Sharp St Date signed 3/11/48

correct age is especially important. Physicians: please write the cause of death clearly.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 61097

61097 117853

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospital. 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 8 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 708 W. Cross ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carrie M Vetters

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: FEM

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced. WIDOW

6 (b) Name of husband or wife WM VETTERS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July. 13 -1864

8. AGE: Years 83 | Months 67 | Days 26 | If less than one day hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name George Stewart
13. Birthplace MD.

MOTHER
14. Maiden Name Margaret Dempsey
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3 - 13 - 48 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location OLD FREDERICK RD

18 (a) Funeral director Bernard C Hartz
(b) Address 121 E West St

19 (a) MAR 11 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 9 - 1948, at 3.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3 - 1 - 1948, to 3 - 9 - 1948, and that I last saw her alive on 3 - 9 - 1948

	Duration
Immediate cause of death Peritonitis with fecal fistula	9 days
Due to Ruptured Appendix?	?
Due to Carcinoma of Cecum?	?
Other Conditions Arteriosclerotic Cardio-vascular disease (Include pregnancy within 3 months of death)	

Date of operation 3/6/48

Major findings of operation: Abdominal Wall abscess with fecal fistula

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. Lareau M.D.
Address Baltimore City Hosp. Date signed 3/10/48

X

VS 150

661098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

✓ 661098 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Franklin Sq. Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 42 days
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 208 S. Lechmere (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Kerby, Theodore V.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Clara V (Stull)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 27, 1875

8. AGE: Years	Months	Days	If less than one day
73	0	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Meat Packer
11. Industry or business

FATHER
12. Name Theodore Kirby
13. Birthplace U.S.A.

MOTHER
14. Maiden Name Joana O'Gorman
15. Birthplace Ireland

16 (a) Informant Augusta Kirby
(b) Address 2542 Frederick Ave

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MARCH 15 1948 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location OLD FREDERICK RD

18 (a) Funeral director Harry A Wirtzle
(b) Address 440 Edmondson Ave

19 MAR 11 1948 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 10 1948, at 10 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24 1948 to Mar 10 1948 and that I last saw him alive on Mar 10 1948

Immediate cause of death	Duration
Terminal Bronchopneumonia	
Due to Generalized Gentaster	
Due to Ruptured Colon	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Jan 25, 1948
Major findings of operation: Ruptured Colon
of autopsy Gen. Peritonitis. Necrosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph G Schenk M. D.
Address Franklin Sq. Hosp Date signed Mar 48

VS 150

X

1099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. G61099

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Agnes Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 0+ mos 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 711 Devonshire Rd (29
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Georgia Weaver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Joseph C.
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 7 1896

8. AGE: Years	Months	Days	If less than one day
51	10	2	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name — MORINGSTAR
13. Birthplace MO

MOTHER
14. Maiden Name —
15. Birthplace MO

16 (a) Informant JOSEPH C. WEAVER
(b) Address 711 DEVONSHIRE RD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MARCH 13 1948 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location 3801 FREDERICK RD

18 (a) Funeral director Harry H Weitzel
(b) Address 4101 Edmondson Ave

19 (a) MAR 11 1948 (Date filed by registrar) Huntington Williams, Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/9 1948 at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11- 1947 to 3/9 1948
and that I last saw h[illegible] alive on 3/9 1948.

Immediate cause of death Cardiac failure - Myocardial Degeneration Congestive heart failure

Due to Rheumatic Heart

Due to Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 3/9/48 Date signed 3/9/48

VS 183

61100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. 61100

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 118 S. Hilton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 or 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 118 S. Hilton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Baldwin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife William T. Baldwin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 6, 1860

8. AGE: Years	Months	Days	If less than one day
87	6	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Morrow
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Caroline Ritter
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Mary A. Griffin
(b) Address 118 S. Hilton St.

17 (a) Burial (b) Date thereof March 12, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miles Lanahan
(b) Address 4510 Liberty Heights Ave.

19 (a) MAR 11 1948 Remington for Williams, Md.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1948, at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1948 to March 9, 1948, and that I last saw her alive on March 9, 1948

Immediate cause of death	Duration
Heart failure	
Due to Hypertension	
arteriosclerosis	
Due to	
Other Conditions Inanition; senility	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis R. Moser M. D.
Address 4335 Park Heights Ave. Date signed 3/10/48

VS 150

correct age is especially important. Physicians: please write the cause of death plainly.

G61101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G61101

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph Hosp 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 N. Streeper St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas E. Command

3 (b) If veteran, name war No

3 (c) Social Security Account No. 212-03-5488

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed.

6 (b) Name of husband or wife Barbara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3 1881

8. AGE: Years 67 | Months | Days 6 | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name John Command

13. Birthplace Ireland

MOTHER 14. Maiden Name Catharine ?

15. Birthplace Ireland

16 (a) Informant Kathryn Command

(b) Address 112 N. Streeper St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 13 48 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Eastern Ave Rd

18 (a) Funeral director Dugal Bros.

(b) Address 1800 E. Lombard St.

19 MAR 11 1948 Huntington Williams, M.D. Registrar (Registered by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1948, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1938, to March 9 1948, and that I last saw him alive on March 9 1948.

	Duration
Immediate cause of death: Congestive Heart Failure	2 days
Due to: Cardio-Vascular Hypertensive disease	10 years
Due to: Arteriosclerosis	10 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Michael J. Dausch M. D.

Address 1 W. Chesapeake Ave Date signed 3/10/48

X

VS 150

G61102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$3a ✓

Registered No. G61102

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert ST.

(c) Hospital or institution: Mercy 4-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days ?

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County .....

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 701 W. Mulberry

(If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Arthur Gray

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan-1-1904

8. AGE: Years	Months	Days	If less than one day
44 43	? 2	? 9	..... hr. ..... min.

9. Birthplace Greenville S. C.

(Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business .....

FATHER

12. Name Wells Gray

13. Birthplace S.C.

MOTHER

14. Maiden Name Mary Griffield

15. Birthplace S.C.

16 (a) Informant Nancy Green } Sister

(b) Address 307 Myrtle ave }

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-48 (month) (day) (year)

(c) Cemetery or crematory .....

Location Mt. Calvary

18 (a) Funeral director A. Halstead

(b) Address 918 Druid Hill

MAR 11 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-10- 1948 at 5:1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 9 1948 to March 10 1948 and that I last saw him alive on March 10 1948.

Immediate cause of death Intracranial Hemorrhage

Due to ?

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: none

of autopsy: .....

Duration
.....
.....
.....
.....
.....
.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....

(Specify type of place)

(e) Means of injury .....

23. Signature Jane M. Brogan M. D.

Address Mercy Hospital Date signed March 10 1948

VS 150

51103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registered No. 64103

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15th Division St.
(c) Hospital or institution: Provident 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 48 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 Madison Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Sherman Grant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	N	Married

6 (b) Name of husband or wife Lula Grant

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/15/88

8. AGE: Years	Months	Days	If less than one day: hr.	min.
49	8	25		18 99

9. Birthplace Florence, S. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Henry Grant
13. Birthplace S. C.

MOTHER
14. Maiden Name Virginia?
15. Birthplace S. C.

16 (a) Informant Lula Grant
(b) Address 1625 - Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-14-48 (month) (day) (year)
(c) Cemetery or crematory
Location Arbutus

18 (a) Funeral director A. Halstead
(b) Address 918 - Druid - Hill

19 MAR 11 1948 (Date rec'd by registrar) (by) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10 1948 at 1:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/8 1948 to 3/10 1948 and that I last saw h[illegible] alive on 3/10 1948

Immediate cause of death	Duration
Lymphatic Leukemia	
Due to	
Due to	2-3 days
Other Conditions Myocardial Failure (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation: Splenic Enlargement

of autopsy Typical Lymphadenosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Preston Grant

Address 15th Division Date signed 3/10/48

VS 150

Please write the cause of death correctly. Physicians: please write the correct age is especially important.

61104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. G61104

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3928 Clovehill Rd.
(c) Hospital or institution 3928 Clovehill Road 12-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3928 Clovehill Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Haymon
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Elijah R. Haymon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1860

8. AGE: Years	Months	Days	If less than one day
86	3	14	hr. min.

9. Birthplace Woodstock Co Md (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Abed Pagne
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Jones
15. Birthplace Md

16 (a) Informant Mrs Mesner
(b) Address 3928 Clovehill Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/48 (month) (day) (year)
(c) Cemetery or crematory Salem Methodist
Location Pikesville Balto Md

18 (a) Funeral director Dennis & Watson
(b) Address Parkville Md

19 (a) MAR 11 1948 (Date rec'd by registrar) (b) Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1948 at 7.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to March 11 1948 and that I last saw h alive on March 10 1948

	Duration
Immediate cause of death Myocardial Infarction	
Due to Myocardial Infarction	16 yrs.
Due to Hypertension	20 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert M Foster M. D.
Address 2824 St. Paul St Date signed March 11-48

VS 150

correct age is especially important. Physicians, please write the cause of death plainly.

G61105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

§ 3a

G61105 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT ST
(c) Hospital or institution:
MERCY HOSP. 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 843 McALEER CT. 2
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT CONNOR

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) MARCH 9, 1871

8. AGE: Years	Months	Days	If less than one day
77 78	-	1	hr. min.

9. Birthplace BALTIMORE (Town, county, and state)
10. Usual Occupation UNIMPLOYED
11. Industry or business

FATHER
12. Name JOSEPH CONNOR
13. Birthplace BALTIMORE

MOTHER
14. Maiden Name AMELIA ?
15. Birthplace ?

16 (a) Informant ADM. SLIP
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 12/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem
Location Balto Co Md
18 (a) Funeral director Welsh Funeral Home
(b) Address 2008 Orleans St Thursday for Pottsville, Pa

19 (a) MAR 11 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10 1948 at 1 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/7 1948 to 3/10 1948 and that I last saw h 1 alive on 3/10 1948

Immediate cause of death CEREBRO-VASCULAR ACCIDENT (HEMORRHAGE) — Duration
Due to HYPERTENSION
Due to ARTERIOSCLEROSIS GENERALIZED.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Elden H. Pentz M.D.
Address Mercy Hosp Date signed 3-12-48

VS 150

correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 61106

61106 13/a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3233 Dudley Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3233 Dudley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth A. Lorenz

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Charles J. Lorenz
6 (c) If alive, give age yrs.

7. Birth date of deceased (mo., day, yr) May 23, 1871

8. AGE: Years 76 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and State)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Radford
13. Birthplace Ireland

MOTHER
14. Maiden Name Ida Schroeder
15. Birthplace Germany

16 (a) Informant Mrs. H. Gayle Morgareth
(b) Address 3233 Dudley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-12-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director John A. Morgan
(b) Address 3600 E. Baltimore St.

19 (a) MAR 13 1948 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1948 at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 3 1946 to March 8 1948 and that I last saw him alive on March 8 1948

Immediate cause of death
(a) Chronic Myocarditis
Chronic Interstitial Nephritis

	Duration
	1940
	1940
	1942
	1948

Due to Mitral Stenosis

Due to

Other Conditions Acute Cardiac Dilatation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. L. Brady M. D.
Address 5035 Linden Ave Date signed 3-9-48

VS 150

X

Please write in the cause of death, correct age is especially important. Physicians: please write the cause of death, correct age is especially important.

C61107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No. C61107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3302 Royce Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-10
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3302 Royce Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Barnum Bloch

3 (b) If veteran, name war:

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Maggie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1869

8. AGE: Years 79 | Months 1 | Days 11 14 | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER
12. Name Borah Bloch
13. Birthplace Russia

MOTHER
14. Maiden Name Unkown
15. Birthplace Russia

16 (a) Informant Mrs Maggie Bloch
(b) Address 3302 Royce Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 12, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run Cem
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 14 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 11 - 1948, at 6 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/14 1947, to 3/10 1948, and that I last saw him alive on 3/10 1948.

Immediate cause of death: Acute Cardiac failure — Duration

Due to: Carcinoma of Prostate

Due to:

Other Conditions: Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 204 E. Biddle St. Date signed 3/11/48

correct age is especially important. Physicians, please write plainly.

51108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. 66108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Division
(c) Hospital or institution: Division Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Severna Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME Emory Franklin Ecker

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-18-0004

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 29-1867

8. AGE: Years 80 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace York Pa (Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER
12. Name Samuel Ecker
13. Birthplace York Pa

MOTHER
14. Maiden Name Margaret Schaners
15. Birthplace Lancaster Pa

16 (a) Informant Louis Henry Ecker
(b) Address Severna Park Anne Arundel Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 12-1948 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Baltimore

18 (a) Funeral director George L. Schwatt
(b) Address 2101 Frederick Ave

19 (a) MAR 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1948, at 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/26 1946 to 3/10 1948 and that I last saw h[illegible] alive on 3/7 1948

Immediate cause of death	Duration
Carcinoma of bladder	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert J Shorb M. D.
Address 2302 Edmondson Ave Date signed 3/10/48

correct age is especially important. Physicians: please write the cause

VS 150

61109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G61109

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2627 Hampden Ave.
(c) Hospital or institution: 12-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2627 Hampden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Montzuma Grant Baker.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Wm. A. Baker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1864

8. AGE: Years	Months	Days	If less than one day
83	4	9	hr. min.

9. Birthplace Maryland.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William A. Hodges.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Unknown.

16 (a) Informant Mrs. Richard Merson.
(b) Address 3552 Buena Vista Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 13/48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Memorial
Location Washington Blvd.

18 (a) Funeral director Austin E. Donovan.
(b) Address 3617 Chestnut Ave.

19 (a) MAR 12 1948 (Date rec'd by registrar) (b) Huntington Hollingsworth, M.D. Registrar

MEDICAL CERTIFICATION P.

20. DATE OF DEATH March 10, 1948 at 4.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 12 1947 to March 10 1948, and that I last saw her alive on March 10 1948.

Immediate cause of death Arteriosclerotic heart disease — Duration 25 yr.

Due to

Due to

Other Conditions Diabetes, Malnutrition — ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Adam J. Lewis M. D.
Address 6232 Belair Road Date signed March 12, 1948

VS 150

Adam J. Lewis MD

G61110 SOLOMON ✓ G61110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4112 Norfolk Ave 15-4
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4112 Norfolk Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ball Solomon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Esther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Real Estate

11. Industry or business

FATHER
12. Name Abrahaye
13. Birthplace Lith

MOTHER
14. Maiden Name Pessie
15. Birthplace Lith

16 (a) Informant Esther Solomon
(b) Address 4112 Norfolk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-12-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2106 Eutaw Place

19 (a) MAR 12 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-11-1948 at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 7 1948 to March 11 1948, and that I last saw h. alive on March 11 1948

Immediate cause of death: Myocardial infarction — Duration: 5 min.

Due to: arteriosclerosis — unknown

Due to: coronary thrombosis — over

Other Conditions: mass in abdomen — unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul F. Cureton M. D.

Address 217 South Rd Date signed 3-12-48

correct age if especially important

VS 150

X

61111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 61111

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1466 Montepelier St.
(c) Hospital or institution: 9-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1466 Montepelier St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Francis J. MacKenzie

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-20-7187

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Louise MacKenzie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 6th 1870

8. AGE: Years	Months	Days	If less than one day
78	1	4	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Francis J. MacKenzie
13. Birthplace —

MOTHER
14. Maiden Name Catherine Huerich
15. Birthplace —

16 (a) Informant Mrs. Louise MacKenzie
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13th 1948 (month) (day) (year)
(c) Cemetery or crematory Balto
Location E. North Ave Ext

18 (a) Funeral director Leo J. Cook
(b) Address 1201-03 N. Patterson Park Ave

19 (a) MAR 12 1948 (Date rec'd by registrar) (b) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-10th 1948 at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1948 to Mch 10 1948 and that I last saw h— alive on March 9 1948

Immediate cause of death — Duration

Due to Apoplexy — 1 mo

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature 200 Hubbard Bldg M. D.
Address Date signed

X Mch 11 1948

correct age is especially important

VS 138

61112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 130

Registered No. 61112

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1330 Aisquith St
(c) Hospital or institution: 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1330 Aisquith St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen T. (Nellie) Murray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1873

8. AGE: Years 74 | Months 2 | Days 21 18 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation House work

11. Industry or business Home

FATHER
12. Name Patrick Murray
13. Birthplace Ireland

MOTHER
14. Maiden Name Ann Gordon
15. Birthplace Ireland

16 (a) Informant Mrs. Geo Wortman
(b) Address 1328 Aisquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 13, 1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St

19 MAR 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 15 1948 to Mar. 10 1948 and that I last saw her alive on Mar. 9 1948

Immediate cause of death	Duration
Pulmonary tuberculosis	2 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Kramer M. D.
Address 1402 Fanvale Date signed 3.11.48.

VS 150

Dr. Kramer 1402 Fanvale St

61113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

Registered No. G61113

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution: 22-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 535 West Bare St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Birdie Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Laurence Baker
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) May 10, 1903

8. AGE: Years	Months	Days	If less than one day
94	10	1 -	hr. min.

9. Birthplace Georgia (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name James Lowery
13. Birthplace South Carolina

MOTHER
14. Maiden Name Elizabeth Lowery
15. Birthplace Georgia

16 (a) Informant Mrs Laurence Baker
(b) Address 535 West Bare St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 14, 1948 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Cemetery
Location Baltimore City
(a) Funeral director Joseph A Linky
(b) Address 66 East Bare Street

MAR 12 1948 (Date rec'd by registrar)
Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 10 1948, at 6 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3 - 10 1948 to 3 - 10 1948, and that I last saw her alive on 3 - 10 1948.

Immediate cause of death Cardiac & resp. failure

Due to Neoplasm of rt Lung, upper lobe

Due to Diabetis Mellitus, Hyperthyroidism

Other Conditions Hypertensive C-V Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Neoplasm Rt Lung upper lobe

Duration
over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. L. Jamison M.D.
Address Univ. Hosp. Balto. 21st Date signed 3-11-48

114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

Registered No. C61114

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706 S. Clinton St
(c) Hospital or institution: 26-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 706 S. Clinton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LAWRENCE J. THANNER

3 (b) If veteran, name war None | 3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Sophie Thanner | 6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) July 30, 1884

8. AGE: Years 63 | Months 7 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Balto City

MOTHER / FATHER

12. Name James Thanner

13. Birthplace Germany

14. Maiden Name Theresa —

15. Birthplace Germany

16 (a) Informant Sophie Thanner

(b) Address 706 S. Clinton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 15-1948 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart

Location

18 (a) Funeral director P. J. C. & B. M. Walter

(b) Address Pratt & Stricker Sts

MAR 12 1948 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1948, at 6 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN. 19 48 to March 10 1948, and that I last saw h[im] alive on MAR 10 1948.

Immediate cause of death	Duration
CARDIAC ASTHMA	3 hrs
Due to AC. CARDIAC FAILURE	3 weeks
Due to	
Other Conditions CARCINOMA-LIVER	[illegible]

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James J. Kavanagh M.D.

Address 814 W. Lafayette Ave Date signed 3-7-48 M. D.

correct age is especially important. Physicians: please write the cause of death clearly.

VS 150

95c

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1115 BC-48-05658 160a ✓ Registered No. G61115

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hospital
(c) Hospital or institution: 24-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1215 William St G
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Thomas

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 11 48

8. AGE: Years	Months	Days	If less than one day
			1 hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name William Francis T Thomas
13. Birthplace Baltimore Maryland
14. Maiden Name Agnes Regina Thomas
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Agnes T Thomas
(b) Address 1215 William St G

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-12-1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Flynn & Flynn
(b) Address 1416 Light St

19 (a) MAR 12 1948 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1948, at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 11 1948 to March 11 1948 and that I last saw him alive on March 11 1948

Immediate cause of death	Duration
Respiratory failure	
Due to Post. cerebral accident	
Due to Spontaneous birth & prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William F Carr M. D.
Address Bon Secours Hosp. Date signed 3-11-48

correct age is especially important. Physicians: please write plainly.

X

61116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131B

Registered No. 61116

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home 16-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2041 Harlem Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Patterson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Samjel W. Patterson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1857

8. AGE: Years	Months	Days	If less than one day
90	9	24	hr. min.

9. Birthplace Calvert County, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joseph Hall
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Maryland

16 (a) Informant Mrs. Bessie Hullett
(b) Address 1612 Cold Street

17 (a) burial (b) Date thereof 3/13/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) MAR 12 1948 (b) Thurlington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10, 1948, at 10:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-15 1946 to 3-10 1948, and that I last saw h[illegible] alive on 3-9 1948

Immediate cause of death: Chronic Glomerulo Nephritis — Duration: 3 yrs -
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R. Klenman, M.D.
Address 3803 Edmondson Ave. Date signed 3/11/48

correct age is especially important.

V9 150

X

G61117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G61117

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22-2
(c) Hospital or institution Keith Walker Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 205 W Lombard Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Brown
3 (b) If veteran, name war
3 (c) Social Security Account No. 217-09-5843

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
55-?			hr. min.

9. Birthplace Unknown (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Allie Adams
(b) Address 13 W York St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-12-48 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Balto City

18 (a) Funeral director Isaac L. Brownson
(b) Address 108 W Montgomery St

19 (a) MAR 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1948, at 8:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C.V.
Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil H. Beyer M.D. Medical Examiner
Date signed 3-8-48

VS 151

G61118

HEALTH DEPARTMENT—CITY OF BALTIMORE

G61118

CERTIFICATE OF DEATH

1316 Fawn.

1. PLACE OF DEATH 103 Carlton

CITY OF BALTIMORE: (No. ____ St., 18-K Ward)

Registered No. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ da. How long in U. S. If of foreign birth? ____ yrs. ____ mos. ____ da.

2. FULL NAME Gladys W. Farrow

If U.S. Veteran specify WAR ____

(a) Residence: No. 103 N. Carlton St. St., ____ Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	C	married

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Wm Farrow

6. DATE OF BIRTH (month, day, year) October 20, 1919.

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	28	4	21	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —

10. Date deceased last worked at this occupation (month and year) ____

11. Total time (years) spent in this occupation ____

12. BIRTHPLACE (city or town) (State or country) Balto. Md.

FATHER

13. NAME John Washington.

14. BIRTHPLACE (city or town) (State or country) Baltimore

MOTHER

15. MAIDEN NAME Hattie Washington

16. BIRTHPLACE (city or town) (State or country) Balto. Md.

17. INFORMANT Hyter Anderson

(Address) 221 S. Green St.

18. BURIAL, CREMATION, OR REMOVAL Mt. Auburn

Place Mt. Auburn Date 3-13-1948

19. UNDERTAKER Mrs Kate R. Steggerda

(Address) 322 N. Eutaw St. Baltimore, Md.

20. FILED ____ 19____

Registrar.

MAR 12 1948

OCCUPATION is very important. See instructions.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) March 10, 1948

22. I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1948, to Mar. 10, 1948

I last saw her alive on March 8. Death is said to have occurred on the date stated above, at 1:15 P.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Nephritis	

Other contributory causes of importance

Was an operation performed? No Date of ____

For what disease or injury? —

What test confirmed diagnosis? ____ Was there an autopsy? ____

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ____ Date of injury ____, 19____

Where did injury occur? ____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ____

Manner of injury ____

Nature of injury ____

24. Was disease or injury in any way related to occupation of deceased? ____ If so, specify ____

(Signed) Frank C. Wagner M. D.

(Address) 3027 Leadenhall

G61119

BALTIMORE CITY HEALTH DEPARTMENT ✓ G61119

CERTIFICATE OF DEATH · 13B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 19-7
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 17 Nord Gilmor St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mildred WALLACE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1930

8. AGE: Years 17 | Months 11 | Days 7 | If less than one day hr. min.

9. Birthplace Howard County, Md. (Town, county, and state)

10. Usual Occupation Student.

11. Industry or business

FATHER 12. Name Howard Howard

13. Birthplace Md.

MOTHER 14. Maiden Name Corrine Wallace Copeland

15. Birthplace Md.

16 (a) Informant Corrine Wallace

(b) Address 17 N. Gilmor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15-1948. (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Mrs. Katie R Willia

(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10, 1948 at 9 45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pulmonary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George L. Merrill M.D. Medical Examiner.

Date signed 3/10/48

Correct age is especially important

VS 151

X

G61120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G61120 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green St
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 635 N. Calhoun St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Holmes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	C	married

6 (b) Name of husband or wife Mary Holmes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1887

8. AGE: Years	Months	Days	If less than one day
60	8	5	hr. min.

9. Birthplace Winnsboro, S.C.
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Cornelius Holmes
13. Birthplace Winnsboro, S.C.

MOTHER
14. Maiden Name Maggie Gladden
15. Birthplace Winnsboro S.C.

16 (a) Informant Mrs. Claude Holmes
(b) Address 635 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 13, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) MAR 12 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-10 1948, at 5-10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-10 1948 to 3-10 1948, and that I last saw him alive on 3-10 1948.

Immediate cause of death Cardiac failure

Due to Hypertensive Cardio Vascular disease

Due to

Other Conditions Possible Spontaneous pneumothorax
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. L. Jamison, M.D.
M. D.
Address University Hosp. Balto. Md. Date signed 3-10-48

VS 150

G61121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 93

G61121

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 4-2
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doff
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 621 W Mulberry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAM CARTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife Rosa Carter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 22, 1901

8. AGE: Years	Months	Days	If less than one day
46	6	16	hr. min.

9. Birthplace Wallace, N.C. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Carter
13. Birthplace N.C.

MOTHER
14. Maiden Name Eliza
15. Birthplace N.C.

16 (a) Informant Rosa Carter
(b) Address 621 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 12, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) 1948 (Date received by registrar) (b) Katie Williams M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 3/7/48 19 , at 4:35 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Time death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D. (Medical Examiner)
Date signed 3/8/48

122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

Registered No. 661122

1. PLACE OF DEATH: Baltimore
(a) Baltimore City, Maryland
(b) Street address 422 N. Gilmor St.
(c) Hospital or institution: 19-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 422 N. Gilmor St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Mong

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/13

8. AGE: Years	Months	Days	If less than one day hr.	min.
35 Yr				

9. Birthplace Ellisville Ga
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Moye.
13. Birthplace Ellisville Ga

MOTHER
14. Maiden Name Cassie Nathan
15. Birthplace Ellisville Ga.

16 (a) Informant Cassie E. Mitchell
(b) Address 422 N. Gilmor St

17 (a) Burial (b) Date thereof 3/13/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co. Md.

18 (a) Funeral director Metropolitan Funeral Home Inc
(b) Address 907 N. Mount St.

19 (a) MAR 12 1948 (b) Huntington W. Va.
(Must not be day registered)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1948, at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1948 to March 11 1948 and that I last saw h. l. alive on March 11 1948

Immediate cause of death
Congestive Heart Failure — Duration 5 Weeks
Due to
Due to Luetic Heart Disease
Other Conditions Cancer

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. Beckham, M.D.
Address 425 N. Gilmor St Date signed 3/12/48

VS 150

PLEASE WRITE PLAINLY. Physicians: please write the cause of death in such terms as will convey to the undertaker and to the Health Officer a correct idea of the disease or condition which caused death. The correct age is especially important.

661123 661123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 14-3
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Entire

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1902 Madison Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country None

3 (a) FULL NAME Emma McNeFee

3 (b) If veteran, name war None | 3 (c) Social Security Account No.

4. Sex Fe | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16 1872

8. AGE: Years 76 | Months | Days 27 | If less than one day hr. min.

9. Birthplace Front Royal, Va. (Town, county, and State)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Thomas McNeFee

13. Birthplace Virginia

MOTHER 14. Maiden Name Amanda Fallen

15. Birthplace Virginia

16 (a) Informant Miss Florence McNeFee

(b) Address 1902 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-12-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Wm. Geo. H. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) (b) (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10 1948 at 8:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/5 1948 to 3/10 1948 and that I last saw h[illegible] alive on 3/10 1948

Immediate cause of death	Duration
Arteriosclerosis	
Due to Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Williams Barnes M.D.

Address 1514 Division St Date signed 3/11/48

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians, please write

VS 150

G61124 ✓ G61124

GM. 117551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 1-2
(c) Hospital or institution:
Baltimore City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 23 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 63 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 320 S. Robinson ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Luczekowski (LUCZKOWSKI)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Frances

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
72 ?			....hr. ....min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER
12. Name ? Anton Luczkowski
13. Birthplace Poland

MOTHER
14. Maiden Name ? Josephine Malecki
15 Birthplace Poland

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Road

18 (a) Funeral director M. F. Sadowski & Sons
(b) Address 1808 Eastern Avenue

19 (a) MAR 12 1948 (Date rec'd by registrar) (b) Huntington Woods, Mich. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 10 - 1948, at 1.08 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2 - 17 - 1948 to 3 - 10 - 1948, and that I last saw him alive on 3 - 10 - 1948.

Immediate cause of death	Duration
Cardiac Insufficiency & Pulmonary Congestion	
Uremia; Bronchopneumonia	
Due to Pulmonary Emphysema	
Benign Prostatic Hypertrophy	
Due to Uremia urinary retention	
Other Conditions Arteriosclerosis, generalized	

(Include pregnancy within 3 months of death)

Date of operation 2/18/48

Major findings of operation: Benign Pros Tatic Hypertrophy with

Findings of autopsy: Uremia retention

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank L. Lanza M.D.
Address Baltimore City Hosp Date signed 3/10/48

VS 150

correct age is especially important

61125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92E

Registered No. 61125

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution: Twilight Rest & Nursing Home 7-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 509 N. Curley Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN OLSZEWSKA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Ernest
6 (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) May 23, 1883

8. AGE: Years	Months	Days	If less than one day
64	9	19	hr. min.

9. Birthplace Odessa, Russia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Mrs. Elizabeth Hebrank
(b) Address 3201 E. Leverton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Road

18 (a) Funeral director M. F. Sadowski & Sons
(b) Address 1808 Eastern Avenue

19 (a) MAR 12 1948 (Date rec'd by registrar) (b) Thursday for Wednesday

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10/48 19 , at 1 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/2/48 19 to 3/10/48 19 and that I last saw h[illegible] alive on 3/9/48 19

Immediate cause of death Acute Myocarditis

Due to Endocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Uncertain
Uncertain

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 401 S Edmondson Ave Date signed 3/12/48

correct age is especially important. Physicians, please

VS 150

G61126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

G61126 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 17-1
(b) Street address
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6½ Mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 931 Shields Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl PARKER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed, or divorced~~
Male	Colored	Married

6 (b) Name of husband or wife Maggie Parker
6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) 6/8/11

8. AGE:	Years	Months	Days	If less than one day
	36	9		____ hr. ____ min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Pepsi Layer
11. Industry or business

FATHER
12. Name John Parker
13. Birthplace Md

MOTHER
14. Maiden Name Ada Parker
15. Birthplace Md.

16 (a) Informant Maggie Parker
(b) Address 924 Shields Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-11-48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Cemetery
Location Mt. Auburn

18 (a) Funeral director Williams-Jackson
(b) Address 916 Penna Ave

19 MAR 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1948, at 12 06 AM

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet-wound of thoracic spine and spinal cord, with
~~Due to~~ paralysis of legs, bed-sores, infection of bladder, and
~~Other Conditions~~ severe pyelonephritis.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/22/48 at 12 15 A. M.
(b) Where did injury occur Cobble of Bradley St
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No
(d) Means of injury Firearms

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 3/9/48

VS 131

1127 Asler-2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G61127 Registered No. new

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5-2
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 301 Forrest St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sidney Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/1905

8. AGE: Years	Months	Days	If less than one day
42	11		hr. min.

9. Birthplace Royce va (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name Sidney Carter
13. Birthplace va

MOTHER
14. Maiden Name Lucy Barber
15. Birthplace va

16 (a) Informant Elizabeth Carter
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-12-48 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Mt. Auburn

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna ave

19 MAR 10 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10 1948, at 12 0 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/9 1948 to 3-10 1948 and that I last saw him alive on 3/10 1948.

Immediate cause of death Lobar Pneumonia — Duration 48 hrs
Due to R.H. due to B. Tuberculosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature F. D. Hughes M. D.
Address John Hopkins Hospital Date signed 3-14-48

VS 150

C61128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1243

Registered No. C61128

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 406 E. Gittings Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) about 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. J. (b) County
(c) City or town Belleville (If outside city or town limits, write RURAL and give town)
(d) Street No. 37 Smallwood Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Helen Frances Hindes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Joseph Vansant Hindes
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) 1/18/98

8. AGE: Years 50 | Months 1 | Days 21 | If less than one day ?? hr. min.

9. Birthplace Illinois (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Anthony Floyd
13. Birthplace Ill.

MOTHER
14. Maiden Name Katherine Dunn
15. Birthplace Ill.

16 (a) Informant H. Cookman Hindes
(b) Address 406 E. Gittings Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location 3801 Frederick Ave., Baltimore

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) MAR 12 1948 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1948, at 9.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1948 to March 10 1948.
and that I last saw h[illegible] alive on March 10 1948

Immediate cause of death: Cirrhosis of Liver — Duration: 4 yrs.
Due to:
Due to:
Other Conditions: Pseudomyxoma of ovary 4 yrs

(Include pregnancy within 3 months of death)
Date of operation Jan 20 1948
Major findings of operation: cirrhosis liver, ascites, myxoma fluid
of autopsy: none

PHYSICIAN Underline the cause to which death should be charged Statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. S. Chalfant M. D.
Address 6210 York Road Date signed March 12 48

correct age is especially important.

VS 133

Dr. Chalfant

61129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164E

Registered No. 661129

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27-13
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 Edgevale Rd. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME John D. Lancaster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Susanne Landis

6 (c) If alive, give age 23 years

7. Birth date of deceased (mo., day, yr.) August 3, 1915

8. AGE: Years	Months	Days	If less than one day
32	7	7	____ hr. ____ min.

9. Birthplace Springfield, Mass. (Town, county, and state)

10. Usual Occupation Public Relations

11. Industry or business Vultee Corp.

FATHER
12. Name Henry Carrington Lancaster
13. Birthplace Richmond, Va.

MOTHER
14. Maiden Name Helen Clark
15. Birthplace Northampton, Mass.

16 (a) Informant Henry C. Lancaster
(b) Address 604 Edgevale Road

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof March 12/48 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location North & Greenmount aves

18 (a) Funeral director John D. Mitchell Sons
(b) Address 1918 Eastern Place

19 (a) MAR 12 1948 (Date rec'd by registrar) (b) [illegible] Registrar, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1948 at 8 P M

21. I certify that I took charge of the remains described above, held an Inquest Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Multiple Fractures
Internal Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-10-48 at 7-9 P.M.
(b) Where did injury occur? Equitable Bldg.
(c) Did injury occur at home, on farm, industrial place, in public place? Office Bldg. While at work? no.
(d) Means of injury Jumped from 6th flr. window

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 3-11-48

VS 181

61130 JL - 107370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 61130

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Kent
(c) City or town [redacted] 1
(If outside city or town limits, write RURAL and give town)
(d) Street No. Chestertown, Kent Co., Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Aldridge

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife William Samuel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1855

8. AGE: Years	Months	Days	If less than one day
92	4	14	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Frisby Taylor
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Harlock Webb
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/48 (month) (year)
(c) Cemetery or crematory Loudon Park
Location 3501 Frederick Ave., Balto.

18 (a) Funeral director John O. Mikkelsen & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) MAR 12 1948 (Date rec'd by registrar) (b) [illegible] for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8, 1948, at 12.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 6 1947 to Mar. 8 1948, and that I last saw her alive on March 8 1948.

Immediate cause of death	Duration
Cardiac Insufficiency	9
Due to Hypertensive Arterio-sclerotic Cardiovascular Disease	years
Due to	
Other Conditions Sen. & Bycloses, Malnutrition	2 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Laurence Lee Jr. M. D.
Address Baltimore City Hosp Date signed 3-10-48

VS 150

1131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 561131

1. PLACE OF DEATH: 15-9

(a) Baltimore City, Maryland

(b) Street address Caynes c Dukeland

(c) Hospital or institution: West Balto Gen Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4111 Forest Park Avenue (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Moses a Morris Liebfeld

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Pearl

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1898

8. AGE: Years	Months	Days	If less than one day
49	5	25	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business Plumber

FATHER 12. Name Louis Liebfeld

13. Birthplace Poland

MOTHER 14. Maiden Name Deborah ?

15. Birthplace Poland

16 (a) Informant Pearl Liebfeld

(b) Address 4111 Forest Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 14 48 (month) (day) (year)

(c) Cemetery or crematory Hebrew Rosedale Cemetery

Location Hamilton Ave, Rosedale

18 (a) Funeral director Sol Ellinson & Bros

(b) Address 1124 E. North Ave. Baltimore, Md

19 (a) MAR 12 1948 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1948 at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 11 1948 to March 11 1948 and that I last saw h[illegible] alive on March 10 1948.

	Duration
Immediate cause of death Cardiac Failure	1 hr
Due to Myocardial Infarction	1 hr
Due to	
Other Conditions Coronary Thrombosis	1 yr

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Harry Cashman M.D

Address 3 No Garrison Blvd Date signed 3/11/48

correct age is especially important. If unknown, please state approximate age.

V S 150

661132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 661132

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6238 Belair Rd
(c) Hospital or institution: 27-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6238 pelair Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANDREW WRIGHT GERMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	None	M	W	Married

6 (b) Name of husband or wife Annie J. German
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1874

8. AGE: Years	Months	Days	If less than one day
73	5	27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business City Fire Dep't

FATHER
12. Name Andrew German
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Mollen
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Annie J. German
(b) Address 6238 pelair Rd.

17 (a) Burial (b) Date thereof 3/13/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) MAR 12 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 11 1948, at 3:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 2 1947, to Mar 11 1948, and that I last saw h alive on Mar 11 1948

Immediate cause of death	Duration
Cardiac failure, pulmonary edema	18 hours
Due to Arteriosclerotic heart disease	15 yrs.
Due to	
Other Conditions Generalized Carcinomatosis, Carcinoma of sigmoid	4 yrs.

(Include pregnancy within 3 months of death)
Date of operation 1944
Major findings of operation: CA of sigmoid
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Adams G Sears M. D.
Address 6232 Belair Rd Date signed Mar 11, 1948

correct age is especially important

VS. 159

X

G61133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G61133 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St. 15-7
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3321 Guilford Falls Parkway-16
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Rose C. Forestie

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Anthony A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-7-1867

8. AGE: Years	Months	Days	If less than one day
81	2	4	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name — Cortino
13. Birthplace Unknown

MOTHER
14. Maiden Name Maria Bottano
15. Birthplace Unknown

16 (a) Informant Miss Antoinette Forestie
(b) Address 3321 Guilford Falls Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Bagley & Farley
(b) Address Baltimore & Fayette Sts.

19 MAR 12 1948 (Date rec'd by registrar) (Signature for Williams, M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1948, at 11 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 11 1948 to March 11 1948 and that I last saw h.e. alive on March 11 1948.

Immediate cause of death	Duration
Respiratory failure	
Due to Bilateral bronchopneumonia	
Due to Degenerative C.V.D.	
Other Conditions Fracture of neck of R. femur (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 15/7
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 3/10/48 at Noon M
(c) Where did injury occur? 3321 Guilford Falls (City or town) (County) Parkway
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Missed step, fell to floor

23. Signature William F. Lee M. D.
Address Bon Secours Hosp. Date signed 3-11-48

correct age is especially important for females

VS 180

Howard L. Mielkein, M. D.

61134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G61134

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 27-18
(b) Street address 1200 Valley St
(c) Hospital or institution:
Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3500 Hayward ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Hare (Clara Ellen Hare)

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widow

6 (b) Name of husband or wife John Hare (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 1854

8. AGE: Years	Months	Days	If less than one day
94	2	1	hr. min.

9. Birthplace Galveston Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Patrick Kearns
13. Birthplace Ireland

MOTHER
14. Maiden Name Marg. Martin
15. Birthplace Ireland.

16 (a) Informant Lillie Linder Home Poor
(b) Address 1200 Valley St

17 (a) Burial (b) Date thereof 3/13/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director C. Wm. Lemmon
(b) Address 1948 4611 Park Heights

MAR 12 1948

19 (a) (Date rec'd by registrar) (b) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1948, at 12:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 1 1948, to Mch 10 1948, and that I last saw her alive on Mch 9 1948.

Immediate cause of death	Duration
Edema Lungs	2 days
Due to Chronic Myocarditis	5 yrs
Due to	
Other Conditions Arterio Sclerosis	10 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North ave Date signed 3/10/48

VS 150

61135 51990
48-03981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G61135
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13-7
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4602 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby "B" McCormack

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-21-48

8. AGE: Years	Months	Days	If less than one day
		15	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name —

13. Birthplace —

MOTHER

14. Maiden Name Hermina McCormack

15. Birthplace Md

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/48 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director C. Kemp Lippy

(b) Address 764 Park Ave.

19 (a) MAR 12 1948 (Date rec'd by registrar) Certificate from Williams M.D. Registrar

MEDICAL CERTIFICATION

30

20. DATE OF DEATH March 7 1948, at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 21 1948 to March 7 1948 and that I last saw her alive on March 7 1948

Immediate cause of death Prematurity

Due to 800 gms (Birth weight)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Philip Prince

Address John Hopkins Hosp Date signed 8 Mar 48

VS 150

61136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G61136

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 29 N. Bruce St
(c) Hospital or institution: — 19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 29 N. Bruce St (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Phillip Brewer

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	col.	married

6 (b) Name of husband or wife Alice Brewer
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Mar 4, 1881

8. AGE: Years	Months	Days	If less than one day
47	~	~8	hr. min.

9. Birthplace Minrbirk, Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Nathan Brewer
13. Birthplace Md.

MOTHER
14. Maiden Name Matilda ?
15. Birthplace Md ?

16. (a) Informant Mary Tomax (daughter)
(b) Address Minrbirk, Md.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15-48 (month) (day) (year)
(c) Cemetery or crematory Druids Chapel
Location Meripitch, Md.

18. (a) Funeral director H. D. Harding Son & Sons
(b) Address 467 Wash. Blvd. W. Wash. D. C.

19. (a) MAR 12 1948 (Date rec'd by registrar) (b) Lemington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 12 1948, at 5 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1947, to Mar 1948, and that I last saw him alive on July 3 1948

Immediate cause of death	Duration
Cerebral Thrombosis	
Due to Arteria Sclerosis	
Due to —	
Other Conditions Coronary Thrombosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Douglas Shepperd M. D.
Address 4104 Dulaney Ave Date signed 3/13/48

correct age is apparently impossible

VS 150

83B

661137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 935

Registered No. 661137

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 W Ostend St
(c) Hospital or institution: 23-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County B
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 W Ostend St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa M. Archibald

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: No

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Samuel Archibald

6 (c) If alive, give age: 85 years

7. Birth date of deceased (mo., day, yr.): July 25, 1863

8. AGE: Years: 82 | Months: 7 | Days: 13 | If less than one day: hr. min.

9. Birthplace: Pa
(Town, county, and state)

10. Usual Occupation: At home

11. Industry or business:

FATHER
12. Name: Henry Demmers
13. Birthplace: Germany

MOTHER
14. Maiden Name: Christina Drescher
15. Birthplace: Germany

16 (a) Informant: Mrs Elsie Garwood
(b) Address: 110 W. Ostend St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: March 15, 1948 (month) (day) (year)
(c) Cemetery or crematory: Leda Hill
Location: B. A. B.

18 (a) Funeral director: A. Leonard Eyers
(b) Address: 1411 W Lombard St

19 (d) MAR 12 1948 (Date rec'd by registrar) (b) Lemmington for Williamson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11, 1948; at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 48 to March 11 19 48 and that I last saw h[illegible] alive on March 19 48

Immediate cause of death: Chronic myocarditis — Duration: 1 year
Due to: Senility
Due to: Arteriosclerosis
Other Conditions: Generalized — 3 mos.
oedema
(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specific type of place)
(e) Means of injury

23. Signature: Isaac Muller M. D.
Address: 1718 E Clark St Date signed: 3/12/48

correct age is apparently impossible to ascertain

VS 150

61138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

96 ✓

Registered No. 61138

1. PLACE OF DEATH: 25-3

(a) Baltimore City, Maryland

(b) Street address Rayner & Dukeland Aves

(c) Hospital or institution Mercy Baltimore General Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs

(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2819 Indiana Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis Jacob Plitt

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-03-2740

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Helen M. Plitt

6 (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) Aug 16, 1912

8. AGE: Years	Months	Days	If less than one day
35	6	24 ½	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Pressman

11. Industry or business Rotogravure

FATHER

12. Name Louis A. Plitt

13. Birthplace Baltimore Md

MOTHER

14. Maiden Name Minnie B. Jacob

15. Birthplace Baltimore Md

16 (a) Informant Helen M. Plitt

(b) Address 2819 Indiana Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 15, 1948 (month) (day) (year)

(c) Cemetery or crematory Western

Location City

18 (a) Funeral director Mr. Mrs. John W. Tevis & Son

(b) Address 5311 Edmondson Ave

19 (a) MAR 12 1948 (Date rec'd by Registrar) (b) Interring for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-11 1948, at 5:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-11 1948 to 3-11 1948 and that I last saw him alive on 3-11 1948

Immediate cause of death Sub-arachnoid hemorrhage

Due to Spontaneous rupture of

Due to aneurysm of Circle of Willis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Sub-arachnoid Hemorrhage - ruptured

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. W. Bridenbaugh M.D.

Address W. Balto. Gen. Hosp Date signed 3-12-48

VS 190

X

61139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47F

Registered No. 61139

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3723 Brooklyn Ave
(c) Hospital or institution: 25-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3723 Brooklyn Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Adell Berg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Frank Berg Sr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8-1894

8. AGE: Years	Months	Days	If less than one day
53 54	11	23	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Geo F Whittington
13. Birthplace Calvert Co. Md

MOTHER
14. Maiden Name Florence A. King
15. Birthplace Calvert Co. Md

16 (a) Informant Mr Frank Berg Sr
(b) Address 3723 Brooklyn Ave

17 (a) Burial (b) Date thereof 3/15/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Jenkins Cem
Location Jabbonville Md

18 (a) Funeral director Mitton Sahlburg
(b) Address 3914 Hanover St 20

19 (a) 3-9-1948 (b)
(Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10 1948 at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 3 1947 to 3/10 1948.
and that I last saw her alive on 3/10 1948.

Immediate cause of death: Cardiac Arrhest.
Due to: Mesenteric Thrombosis
Due to: Senility contrib.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration
8 hr.
6 Mo.
5 Yrs.
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E W Koons
Address 1202 St Paul Date signed 3/11/48

VS 150

correct age if especially important

61140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1061B

Registered No. 61140

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1140 Forrest St.
(c) Hospital or institution: 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1140 Forrest St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard P. Brown.

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	216 -20 -3166	Male	White	Married

6 (b) Name of husband or wife: Maud Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)	8. AGE: Years	Months	Days	If less than one day: hr.	min.
Aug. 3rd. 1870	77	7	7		

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Richard P. Brown.
13. Birthplace Balti more Md.

MOTHER
14. Maiden Name Rebbeca Slaysman.
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Lula Fonte.
(b) Address 1140 Forrest. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 13th. 48 (month) (day) (year)
(c) Cemetery or crematory Greemont Cem
Location

18 (a) Funeral director Geo. M. Fink & Son
(b) Address 811 N. Wolfe St.

19 (a) MAR 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March. 10th. 1948, at 9 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3 March 1948 to 10 March 1948 and that I last saw h alive on 9 Mar 1948

Immediate cause of death	Duration
Chr. pulmonary chang	probably 10 days
Left. ventricular failure	
Due to Congestive failure	?
arteriosclerosis	
Due to	
Other Conditions Chronic bronchitis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Lubenfeld M. D.
Address 714 E. Preston Date signed 11 Mar

correct age if certainty unknown

V S 150

97

61141 CATHLEEN – LAWLER –

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. 61141

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution: Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ mos
(e) Length of stay in Baltimore (yrs., mos., or days) 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 W. Pratt St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Cathleen Lawler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 06

8. AGE: Years	Months	Days	If less than one day
42	4		hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name James Lawler
13. Birthplace Balto Md

MOTHER 14. Maiden Name Mary Feeney
15. Birthplace Balto Md

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/48 (month) (day) (year)

(c) Cemetery or crematory Mount Cathedral
Location Old Frederick Rd

18 (a) Funeral director Thomas F. Feeney Son
(b) Address Hollins & Gilmore Sts

19 (a) MAR 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-10 1948 at 8:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16 1948, to 3-10 1948 and that I last saw her alive on 3-10 1948

Immediate cause of death: Pulmonary Embolism

Due to

Due to

Other Conditions C.A.J. Bon Secours

(Include pregnancy within 3 months of death)

Date of operation 3-9-48

Major findings of operation: Large C.A.J. Primary Duct

of autopsy: C.A.J. Bon Secours

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George W. Fosburgh M.D.
Address Bon Secours Hosp Date signed 3-12

61142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 61142

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 19-2
(b) Street address
(c) Hospital or institution:
FRANKLIN SQUARE
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 W. BALTIMORE ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH UNGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband ~~or wife~~ JOHN UNGER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1897

8. AGE: Years	Months	Days	If less than one day
50	4 2	18	19 hr. min.

9. Birthplace Greenville N. C.
(Town, county, and state)

10. Usual Occupation HOUSE WIFE
11. Industry or business

FATHER
12. Name — RAYFIELD
13. Birthplace N.C.

MOTHER
14. Maiden Name —
15. Birthplace N.C.

16 (a) Informant JOHN UNGER
(b) Address 1616 W. BALTIMORE ST

17 (a) BURIAL (b) Date thereof MARCH 15, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location 3801 FREDERICK RD

18 (a) Funeral director Harry H Wilhelm
(b) Address 4101 Edmondson Ave

19 (a) MAR 12 1948 (b) Huntington Hollinger, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 11 1948, at 7:15 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 3/17/48

VS 151

61148 Osler-6

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 8 1a

G61143

Registered No. new

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 25-2
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2710 Huron St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gordan M. Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1923

8. AGE: Years: 24 | Months: 7 | Days: 14 | If less than one day: hr. min.

9. Birthplace BALTO. MD (Town, county, and state)

10. Usual Occupation PAINTER

11. Industry or business Johns Hopkins Hosp.

MOTHER | FATHER

12. Name EDGAR WILLIAMS

13. Birthplace MD

14. Maiden Name INDIANA HASKEN

15. Birthplace MD

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MARCH 13 1948 (month) (day) (year)

(c) Cemetery or crematory LOUDON PARK

Location 3801 FREDERICK RD

18 (a) Funeral director Henry H Wilson

(b) Address 4101 Edmondson Ave

19 (a) MAR 12 1948 (Date rec'd by registrar) (b) Tunstun Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/11 1948, at 4:45 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11 1948 to 3/11 1948, and that I last saw him alive on 3/11 1948

Immediate cause of death: Meningococcic, type undetermined — Duration: 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: No gross evidence of any cause of death

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. E. Gibson

Address Johns Hopkins Hosp. Date signed 3/12/48 M. D.

Medical Ex Case To be Approved Howard J. Malecio M.D.

661144 Greene F. # 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. 661144

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet St.
(c) Hospital or institution: City morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 525 N. Paca St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John James, Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location PUBLIC CEMETERY MAR 9 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 MAR 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21 1948, at 5 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Found drowned

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury: found 2-21-48 at 4:15 P.M. 4/1

(b) Where did injury occur? Found: Harbor - Ft. Market Pl.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no

(d) Means of injury Found drowned

23. Signature [signature] Medical Examiner. M.D.

Date signed 2-24-48

VS 191

145 #2 Grave # 2 #2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 66 145

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital - D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Unknown (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unidentified

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown

FATHER 13. Birthplace

MOTHER 14. Maiden Name

MOTHER 15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location PUBLIC CEMETERY MAR 9 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) MAR 12 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/7 1948, at 9:05 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature G. B. Columbo M.D. Medical Examiner.

Date signed 2/7/48

VS 191

61146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61146 Registered No.

BC-48-05339 159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 Fort Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Schmidt B'

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/3/48

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore City Md. (Town, county, and state)
10. Usual Occupation Nurse
11. Industry or business Nurse

FATHER
12. Name Albert Schmidt
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Lee
15. Birthplace Strasburg, Md.

16 (a) Informant Mother
(b) Address 1608 Fort Ave., Balto

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location Johns Hopkins Medical School MAR 10 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAR 12 1948 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/4/48 19 , at 5:42 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/3/48 19 , to 3/4/48 19 , and that I last saw him alive on 3/4/48 19 .

Immediate cause of death respiratory failure
Due to premature
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gordon Ferrer
Address Date signed 3/4/48

VS 150

correct age is especially important. Any

X

147

BALTIMORE CITY HEALTH DEPARTMENT

BC-48-05338 CERTIFICATE OF DEATH 159 Registered No. 663147

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ✓
(b) Street address
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days) 1 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 E. Fort Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Schmidt "D"

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/3/48

8. AGE: Years 0 | Months 0 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore City, Maryland (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER 12. Name Albert Schmidt

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Mrs. Catherine Schmidt

15. Birthplace Sparrows Point, Md.

16 (a) Informant Mother

(b) Address 1608 E. Fort Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Loc Johns Hopkins Medical School MAR 10 1948

18 (a) Funeral directo Commissioner of Health

(b) Address

19 MAR 19 1948 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/4/48 19 , at 3 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/3/48 19 , to 3/4/48 19 , and that I last saw him alive on 3/4/48 19 .

Immediate cause of death respiratory failure — Duration

Due to prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gordon Irvin, MD

Address Date signed 3/4/48

M.D.

VS 150

correct age is especially important.

M. D. B. 1203-9

HEALTH DEPARTMENT—CITY OF BALTIMORE

G61148 G61148

CERTIFICATE OF DEATH

1937

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 Arsan Ave St., 14 Ward)

Registered No.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ....yrs....mos....da. How long in U. S. If of foreign birth?....yrs....mos....da.

2. FULL NAME Carrie Bonnell

(a) Residence: No. 517 Arsan Ave. St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

6a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Lloyd James

6. DATE OF BIRTH (month, day, year) June 29, 1886

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
61	8	12	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Phillipi - W. Va.

MOTHER FATHER

13. NAME William Frank Robinson

14. BIRTHPLACE (city or town) (State or country) Phillipi - W. Va.

15. MAIDEN NAME Ida Jane Cole

16. BIRTHPLACE (city or town) (State or country) Phillipi - W. Va

17. INFORMANT Mr. Eppa D. Robinson
(Address) 517 Arsan Ave.

18. BURIAL, CREMATION, OR REMOVAL
Place Phillipi W. Va. Date 3/12/48 19

19. UNDERTAKER WM. J. TICKNER & SONS
(Address)

MAR 10 1948 FILED ..... 19 ..... Registrar.

(OCCUPATION is very important. Be specific.)

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Mar. 11, 1948

22. I HEREBY CERTIFY, That I attended deceased from March 1 1948 to March 11 1948

I last saw h.. alive on March 11 1948 Death is said to have occurred on the date stated above, at 7P m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arterio-Sclerosis	
Cardio-Vascular Disease	
Cardiac Decompensation	March 8.
Pulmonary Edema	

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide?..... Date of injury..... 19.....

Where did injury occur?.....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?
If so, specify.....

(Signed) Paul Lufbery M. D.

(Address) 320 Orchard Ave

61149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 61149

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 642 W. Fayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 642 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Draugelis f Dravels

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-0032

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Lith. (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name John Draugelis
13. Birthplace Lith.

MOTHER
14. Maiden Name ?
15. Birthplace Lith.

16 (a) Informant Edward Mikuski
(b) Address 1319 James St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location A.A. County.

18 (a) Funeral director Joseph Kasinskos Inc.
(b) Address 602 Wash. Blvd.

19 MAR 13 1948 (Date rec'd by registrar) (b) Curtis Bay, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1948, at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 3-12-48

VS 151

X

63150 X 061150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland & Monument
(c) Hospital or institution:
Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore County (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Perry Hall
(If outside city or town limits, write RURAL and give town)
(d) Street No. Camp Chapel Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leonard Rye

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Barbara K. Rye
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9th, 1883

8. AGE: Years	Months	Days	If less than one day
65	2	3	hr. min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)
10. Usual Occupation Truck Farmer
11. Industry or business

FATHER
12. Name George L. Rye
13. Birthplace Germany

MOTHER
14. Maiden Name Annie Klass
15. Birthplace Germany

16 (a) Informant Mrs. Leonard C. Rye
(b) Address Camp Chapel Rd.

17 (a) burial (b) Date thereof 3/16/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Michael's
Location Perry Hall, Md.

18 (a) Funeral director Lazarah Funeral Home
(b) Address 7401 Belair Rd. Williamsport, Md.

19 (a) MAR 15 1948 (b) Huntington Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/12 1948 at 1:47 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/9 1948 to 3/12 1948 and that I last saw h. l. m alive on 3/11 1948.

Immediate cause of death	Duration
Hemorrhage into tumor metastasis-brain	1 day
Due to malignant tumor of placenta-type unknown	6 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Reuben Lurberg M.D.
M. D.
Address Sinai Hosp. Date signed 3/12/48

VS 150

X

61151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 61151

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Dukeland & Rayner

(c) Hospital or institution: W. 3rd Balto. Gen'l Hosp 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days

(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3124 Presstman St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCISCA GREGERSEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife Eyler E. Gregersen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1875

8. AGE: Years	Months	Days	If less than one day
72	7	3	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name - Atlenberger
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. John J. Habert
(b) Address 2229 Longwood St.

17 (a) Burial (b) Date thereof 3/15/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 13 1948 (b) Funeral Director Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1948, at 4:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/29 1948 to March 11 1948. and that I last saw her alive on 3/11 1948.

Immediate cause of death	Duration
Acute Pulmonary Oedema	
Due to Cerebral Hemmorrhage	
Due to Hypertensive Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Benjamin Berkowitz M. D.

Address West Balto Gen'l Hosp Date signed 3/11/48

VS 139

X

61152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 661152

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Raymond & Dukeland.

(c) Hospital or institution Mt. Pleasant Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2308 Harlem Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET REBECCA HUMPHREYS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b). Name of husband or wife William Edward Humphreys
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1867

8. AGE: Years	Months	Days	If less than one day
80	7	27	hr. min.

9. Birthplace Calvert Co., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name William Hungerford

13. Birthplace Calvert Co., Md.

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant Mr. C. M. Humphreys

(b) Address 411 Lyndhurst St.

17 (a) Burial (b) Date thereof 3/13/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Western Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) MAR 13 1948 (b) Temperance Williams
(Date rec'd by registrar) Registrar

VS 139

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 March 1948 at 7:15 M

21. I certify that death occurred on the date above stated, that I attended deceased from 3/7 1948 to 3/11 1948 and that I last saw h[illegible] alive on 3/10 1948.

Immediate cause of death	Duration
Sepsis and Shock	
Due to Sub Hepatic Abscess	
Due to Cancer Hepatic Flexure with metastases to the liver.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Dr. Lester A. Wall

Address 1 East Read Ave. Date signed 3/11 M. D.

Dr. Lester A. Wall

61153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92c

Registered No. 61153

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. BROADWAY
(c) Hospital or institution: CHURCH HOME & HOSPITAL 13-07
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. Home for Incurables (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Miss DORIS STAMATS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife — None

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) JANUARY 15, 1895

8. AGE: Years	Months	Days	If less than one day
53	1	26	hr. min.

9. Birthplace OHIO (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Mr SEYMOUR STAMATS
13. Birthplace OHIO

MOTHER
14. Maiden Name LAURA SAUNDERS
15. Birthplace OHIO

16 (a) Informant Miss DORIS STAMATS
(b) Address HOME FOR INCURABLES BALTO MD.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/13/48 (month) (day) (year)
(c) Cemetery or crematory Bellefontains, Ohio
Location

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 13 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1948, at 6 40 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 29 1948 to Mar 11 1948 and that I last saw h[illegible] alive on Mar. 11 1948.

Immediate cause of death Acute Cardiac Failure — Duration [redacted]

Due to Rheumatic Heart Disease (Aortic Stenosis) — 34 yrs

Due to

Other Conditions Cancer Bile Duct & Tone — 1 yr

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John M. Culbe
Address Church Home & Hosp Date signed 3-11-48 M. D.

VS 150

X

61154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. 061154

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital ~~or institution~~: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4030 Roland ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3. (a) FULL NAME Carrie S. Stockdale

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-1237

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) Oct 10th 1896

8. AGE: Years	Months	Days	If less than one day
51	5	2	____ hr. ____ min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Telephone Operator
11. Industry or business C & P Tel. Co.

FATHER
12. Name Harry C. Stockdale
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Oliver
15. Birthplace Washington D.C.

16 (a) Informant Harry C. Stockdale
(b) Address 4030 Roland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Moreland Park
Location Parkville Md

18 (a) Funeral director William Cook Inc.
(b) Address 1317 E. Paul St.

19 (a) MAR 13 1948 (Date rec'd by registrar) (b) Huntington Withington

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/12 1948, at 4.35 ^ M

21. I certify that death occurred on the date above stated; that I attended deceased from 19__, to 19__, and that I last saw her alive on 3/12 19 48.

Immediate cause of death Heart Failure
Carcinomatosis
Due to Ca Uterus
Due to Cat metastasis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 3/12 at 4 35 A.M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R A Neubauer, M.D. M. D.
Address Date signed

VS 150

661155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 661155

661155

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — D. 04
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 933 Washington Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia J. Fortney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Helen E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 6th 1882

8. AGE: Years 65 | Months 9 | Days 6 | If less than one day hr. min.

9. Birthplace: Grafton W. Va (Town, county, and state)

10. Usual Occupation: Electrician

11. Industry or business: Baltimore Venetian Blind Co.

FATHER
12. Name: Buckner Fortney
13. Birthplace: W. Va.

MOTHER
14. Maiden Name: Sarah McGinnis
15. Birthplace: W. Va.

16 (a) Informant: Helen E. Fortney
(b) Address: 933 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/48 (month) (day) (year)
(c) Cemetery or crematory: Meadow Ridge
Location: Dorsey Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St.

19 (a) MAR 13 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/12 1948 at 2 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Pelham M.D. Medical Examiner.
Date signed 3/12/48

X

VS 151

661156 JL - 111222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 661156

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2601 E. Biddle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Keith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1879

8. AGE: Years	Months	Days	If less than one day
68	7	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Willian T. Keith
13. Birthplace Md.

MOTHER
14. Maiden Name Mozella Moore
15 Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3/16/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 MAR 13 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1948, at 2.40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1947 to March 12 1948, and that I last saw her alive on March 12 1948.

Immediate cause of death	Duration
Bronchopneumonia	4 days
Due to	
Due to	
Other Conditions Arteriosclerosis Fracture L. Hip Femur	87 days

(Include pregnancy within 3 months of death)

Date of operation 12-23-47

Major findings of operation: as above.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 26/12
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 12-31-47 at A.M.
(c) Where did injury occur? BCH I
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Swimming While at work? no
(Specify type of place)
(e) Means of injury Fell slipped & fell to floor

23. Signature H. C. Steele M. D.
Address 4940 Eastern Ave Date signed 3-12-48

To be approved by Medical Examiner For S. Hillis Hammer Jr. Howard J. Malecki M.D.

VS 150

61157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. 61157

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp. 1 Day
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 16 N. Fulmore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Susie FIELDER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Johnny Fielder | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 17, 1918

8. AGE: Years 29 | Months 5 | Days 23 | If less than one day hr. min.

9. Birthplace Blacksherriff, Ga. (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name J. B. Bell
13. Birthplace Ga.

MOTHER
14. Maiden Name P. Bell
15. Birthplace Ga.

16 (a) Informant Johnny Fielder
(b) Address 16 N. Fulmore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Baltimore, Md.

18 (a) Funeral director Chas R. Low
(b) Address 802 Madison Ave

19 (a) MAR 13 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10, 1948 11 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute congestive cardiac failure due To chronic adhesive pericarditis and chronic rheumatic mitral valvulitis.

Due to
Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 3/10/48

VS 181

61158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33B

Registered No. 61158

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 22

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Frederick
(c) City or town Brunswick
(If outside city or town limits, write RURAL and give town)
(d) Street No. Petersville Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GORMAN B. CHEW

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	married

6 (b) Name of husband or wife Frances Zombro
6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1905

8. AGE: Years	Months	Days	If less than one day
43	6	4	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation B.&O.R.R. Brakeman
11. Industry or business

MOTHER / FATHER
12. Name Joseph C. Chew
13. Birthplace Maryland
14. Maiden Name Daisy Shroyer
15. Birthplace Md.

16 (a) Informant Mrs. Frances Chew
(b) Address Brunswick.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16, 1948 (month) (day) (year)
(c) Cemetery or crematory Harper
Location Harper Ferry W. Va.

18 (a) Funeral director C. F. Fite & Bro.
(b) Address Brunswick, Maryland

MAR 13 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1948, at 11:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-12 1948 to 3-12 1948, and that I last saw him alive on 3-11 1948.

Immediate cause of death	Duration
Pulmonary embolism (?)	
Due to Cardiac irregularity (?)	
Phlebo Thrombosis	
Due to	
Other Conditions Pulmonal Neurysm	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. A. Schumaker M. D.
Address Univ. Hosp Date signed 3-12-48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61159 GM. 117814 — 108 — Registered No. 61159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution: Baltimore City Hospitals 10-03
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. NO Home City Jail (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: John D. Braithwaite

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife: Nannie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27 1883

8. AGE: Years	Months	Days	If less than one day
64	10	14	hr. min.

9. Birthplace VA. (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Bruce (D)
13. Birthplace VA.
14. Maiden Name Nancy (D)
15. Birthplace VA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 14 48 (month) (day) (year)
(c) Cemetery or crematory Bonnie Springs
Location Bonnie Springs Md.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 402 N Wolfe St.

19 MAR 13 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 11 - 1948, at 8.55PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2 - 28 1948, to 3 - 11 - 1948, and that I last saw him alive on 3 - 11 - 1948.

Immediate cause of death: Pneumonia, Lobar Rt Ml — Duration: 5 da
Due to: Silicosis — 1/2 yr
Due to: ASCVD — ?
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Lobar pneum, Silicosis, ASCVD

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William M. Straight M. D.
Address BCH Date signed 6/12/48

VS 150

64160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 64160

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edgury & Fairmount Sts.
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 58 days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTO
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 616 PLYMOUTH ROAD
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB H. DORRIER = Jacob H. Dorrier

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-9089

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: LILLIAN DORRIER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-16-1881

8. AGE: Years 67 | Months 1 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace PENNSYLVANIA (Town, county, and state)

10. Usual Occupation CARPENTER, RETIRED

11. Industry or business

FATHER
12. Name AUGUST DORRIER
13. Birthplace GERMANY

MOTHER
14. Maiden Name MATILDA OSTERLON
15. Birthplace GERMANY

16 (a) Informant PATIENT
(b) Address 616 - Plymouth Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-48 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Baltimore - Md

18 (a) Funeral director F. B. Wippert & Son
(b) Address 1800 Eutaw Place 17

19 (a) MAR 13 1948 (Date rec'd by registrar) (b) Interington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 MARCH 1948, at 2:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3 MARCH 48 to 10 MARCH 48 and that I last saw him alive on 9 MARCH 1948

Immediate cause of death	Duration
ACUTE MYOCARDIAL FAILURE	
Due to GENERALIZED ARTERIOSCLEROSIS	
Due to	
Other Conditions UNUNITED FRACTURE, RIGHT FEMORAL NECK	

(Include pregnancy within 3 months of death)

Date of operation 4 MARCH 48

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Sept. 1947 at ? M
(c) Where did injury occur? 616 Plymouth Rd (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home lawn (Specify type of place) While at work? NO
(e) Means of injury Fall from bean ladder

23. Signature Howard J. Masters, M.D.
Address Church Home Date signed 3-10-48 M. D.

VS 150

61161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. 61161

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Payson Sts.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-1MO
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 128 Willard St.
(If rural give location)
(e) Citizen of foreign country? Not (Yes or No)
If yes, name country

3 (a) FULL NAME David Franklin Carruthers "Carruthers."

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-6205

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edna M. Marshall
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) June 22 1891

8. AGE: Years 56 (57) Months 11 Days 9+11 If less than one day — hr. — min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation U.S. Coast Guard
11. Industry or business " " "

FATHER
12. Name Richard Carruthers
13. Birthplace England

MOTHER
14. Maiden Name Mary Lowther
15. Birthplace Baltimore - Md

16 (a) Informant Edna M. Carruthers
(b) Address 128 Willard - St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director E. B. Shepherd & Son
(b) Address 1 Pea Century Place 17

19 (a) MAR 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1948, at 2:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 11 1948 to Mar 11 1948, and that I last saw him alive on Mar 11 1948

Immediate cause of death: Carcinomas, bronchogenic, right upper lobe, lung — Duration: 5 mos.
Due to:
Due to:
Other Conditions: Lung abscess at upper lobe; Renal insufficiency
(Include pregnancy within 3 months of death)
Date of operation March 8, 1948
Major findings of operation: Lung abscess
Bronchogenic carcinoma at upper lobe.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. B. Levinson M. D.
Address 114 St Paul St Date signed Mar 11 1948

VS 150

X

correct age is especially important

061162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. 061162

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Fayette & Payson Sts
(b) Street address 2147 Pennsylvania Ave
(c) Hospital or institution:
Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2147 Pennsylvania Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Antoinette Korell "KORRELL"

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	married

6 (b) Name of husband or wife Frank Korell
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) 12/7/1875

8. AGE: Years	Months	Days	If less than one day
72	3	4	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife at Home
11. Industry or business

FATHER
12. Name Louis Heiser
13. Birthplace Md

MOTHER
14. Maiden Name ANTIONETTE
15. Birthplace Md

16 (a) Informant FRANK KORRELL
(b) Address 2147 Penna Ave Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore Md

18 (a) Funeral director F. B. WIPPERT. SON
(b) Address 300 Cathedral Street

19 (a) MAR 13 1948 (Date rec'd by registrar) (b) Christopher Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1948 at 2 15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 5 1948, to March 11 1948, and that I last saw her alive on March 11 1948.

Immediate cause of death	Duration
Coal-operative shock	2 hours
Due to Resection of carcinoma of the Rectum	8 wks.?
Due to	
Other Conditions Left hydronephrosis with stone in kidney pelvis (Include pregnancy within 3 months of death)	

Date of operation 2/9/48 and 3/11/48
Major findings of operation: Carcinoma of the rectum
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter B Sanger, M. D.
Address Bon Secours Hospital Date signed 3/11/48

61163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 61163

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution: St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County LORELEI, MD.
(c) City or town Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Gerard Schaech

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-9670

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1912

8. AGE: Years	Months	Days	If less than one day
36	0	20	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation ESTIMATER

11. Industry or business G. L. Martin's AIRCRAFT CO.

FATHER
12. Name JOSEPH J. SCHAECH
13. Birthplace BALTO., MD.

MOTHER
14. Maiden Name JOSEPHINE A. SOTER
15. Birthplace GERMANY.

16 (a) Informant JOSEPH J. SCHAECH
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-15-48 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER CEM
Location BELAIR RD.

18 (a) Funeral director Charles S. Zeiler
(b) Address 901 S. Conkling St.

19 (a) MAR 13 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11, 1948 at 4:35 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 25, 1948 to Mar. 11, 1948 and that I last saw h im alive on March 11, 1948.

Immediate cause of death	Duration
RHEUMATIC HEART DISEASE WITH	
Due to MITRAL STENOSIS AND CONGESTIVE	
Due to FAILURE	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: MITRAL Stenosis

of autopsy Multiple Pulmonary Infarcts

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E May M. D.
Address 1400 N. Caroline St Date signed 3-11-48

correct age is especially important. Physicians, please

VS 150

661164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

661164 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 512 S. Streeper St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 S. Streeper St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William L. Denver Sr.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Veronica Denver
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 1-2-1886

8. AGE: Years	Months	Days	If less than one day
62	2	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Record Clerk.
11. Industry or business Court-House.

MOTHER / FATHER

12. Name Thomas R. Denver
13. Birthplace Md.
14. Maiden Name Emma ?
15. Birthplace Md.

16 (a) Informant Veronica Denver (Widow)
(b) Address 512 S. Streeper St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15-48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location German Hill Rd.

18 (a) Funeral director Charles S. Zeiler
(b) Address 901 S. Conkling St.

19 (a) MAR 13 1948 (Date rec'd by registrar) (b) Burington for William

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11, 1948, at 3:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1945 to Mar 11 1948, and that I last saw him alive on Mar 10 1948.

Immediate cause of death Chronic myocarditis — Duration 1 year

Due to Chronic bronchitis — X years

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Arnold M. D.
Address 101 W Read St Date signed 3-13-48

VS 150

X

61165

AB-112966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 136

Registered No. 61165

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 723 N. Duncan St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ~~Henry Preller~~ HENRY W. PRELLER.

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-01-4567

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8-1896

8. AGE: Years 51 | Months 4 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation BRICK-LAYER.

11. Industry or business SELF.

FATHER
12. Name Conrad Preller
13. Birthplace Germany

MOTHER
14. Maiden Name Molly Gossman
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-16-48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Gem.
Location Herman Mill Rd.

18 (a) Funeral director Charles S. Zeiler
(b) Address 901 S. Conkling St.

19 MAR 13 1948 (Date rec'd by registrar) (b) [illegible] for Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12- 1948, at 9.35AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-13- 1947 to 3-12- 1948, and that I last saw h... alive on 3-12- 1948.

Immediate cause of death Bilateral for advanced pulmonary tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Kirkendall MD

Address Balto City Hosp Date signed 13 Mar 48 M.D.

VS 130

X

661166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. 661166

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2628 Cecil Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2628 Cecil Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James N. Daneker

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2nd 1895

8. AGE: Years	Months	Days	If less than one day
52	7	10	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Wharf

FATHER
12. Name James D. Daneker
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary L. Byrd
15. Birthplace Eastern Shore Md.

16 (a) Informant Mrs Anna E. Daneker
(b) Address 2628 Cecil Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location 3801 Frederick Ave

18 (a) Funeral director John F. Cowan & Son
(b) Address 901-03 Hollins St.

19 (a) MAR 13 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12th 1948, at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946, to Mar 12 1948 and that I last saw him alive on Mar 12 1948

Immediate cause of death	Duration
Acute Cardiac Failure.	
Due to Arteriosclerosis	
Due to Bronchial Asthma	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L B Stevens M. D.
Address 3400 Erdman Ave. Date signed 3/13/48

correct age is especially important

VS 150

G61167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. G61167

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument + Rutland Ave
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4104 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MR EDWARD LONGERBEAM

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ruth E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 16th 1912

8. AGE: Years	Months	Days	If less than one day
36	1	25	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Police Dept.
11. Industry or business Balto. City

FATHER
12. Name Edward O. Longerbeam
13. Birthplace Va

MOTHER
14. Maiden Name Caroline Gately
15. Birthplace Va

16 (a) Informant Mrs Ruth E. Longerbeam
(b) Address 4104 Frederick Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/48 (month) (day) (year)
(c) Cemetery or crematory Dyer Haven Mem. RK
Location Ritchie Highway
18 (a) Funeral director John F. Howard & Son
(b) Address 907 N. Collins St.
19 (a) MAR 13 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1948 at 5 25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1, 1948 to March 12, 1948 and that I last saw h. liv alive on March 12 1948.

Immediate cause of death Uremia — Duration

Due to Acute Exacerbation of Chronic glomerulo-nephritis

Due to

Other Conditions Cardiac failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allan Y. Wolinsky M. D.
Address Sinai Hosp. Date signed 3-13-48

VS 130

X

1168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195E

Registered No. 64168

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Calvert St.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days) None

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Wicomico
(c) City or town Salisbury
(If outside city or town limits, write RURAL and give town)
(d) Street No. Main Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Franklin Bowen Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Louise Hill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1893

8. AGE: Years	Months	Days	If less than one day
54	9	27	hr. min.

9. Birthplace Salisbury, Md.
(Town, county, and state)

10. Usual Occupation Funeral Director
11. Industry or business

FATHER
12. Name George C. Hill
13. Birthplace Md.

MOTHER
14. Maiden Name Mary F.
15. Birthplace Md.

16 (a) Informant Mrs. Louise Hill (wife)
(b) Address Salisbury, Md.

17 (a) Burial (b) Date thereof 3-16-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory —
Location Salisbury, Md.

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 S. Wolfe St. (31)

19 (a) MAR 13 1948 (Date rec'd by registrar) (b) [illegible] Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1948, at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☑ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Subarachnoid Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-13-48 at 12:15 P.M.
(b) Where did injury occur? Front of Emerson Hotel
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? —
(d) Means of injury Fell to floor

23. Signature [signature] M.D.
Medical Examiner.
Date signed 3-13-48

VS 181

261169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 261169

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1063 Harford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1063 Harford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Johanna Mohr

3 (b) If veteran, name war none
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-27-1863

8. AGE: Years	Months	Days	If less than one day
84	2	15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation House work at
11. Industry or business Home

FATHER
12. Name Adam Mohr
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Kolb
15. Birthplace Germany

16 (a) Informant Mrs. Barbara Hower
(b) Address 1660 E. 25 St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 15-48 (month) (day) (year)
(c) Cemetery or crematory Mount Holy Redeemer
Location 4430 Belair Rd.

18 (a) Funeral director Elmer W. Conklin & Son
(b) Address 924 E. Eager St.

19 (a) MAR 13 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 12, 1948, at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/9 1948 to 3/12 1948, and that I last saw her alive on 3/12 1948.

Immediate cause of death Arteriosclerotic Cardio-Vascular Disease — Duration 7

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph S. Bluestein M. D.
Address 1206 E. Baltimore St. Date signed 3/12/48

X

V S 150

61170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 61170

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr 45 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 Madison Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country None

3 (a) FULL NAME Laura Fulford

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fe	Negro	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Domestic

FATHER
12. Name Dan Hutton
13. Birthplace Md

MOTHER
14. Maiden Name Emma Hutton
15. Birthplace Md

16 (a) Informant Mrs Rachel Willoughby (Sister)
(b) Address 633 W Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 16th 48 (month) (day) (year)
(c) Cemetery or crematory Thurston Md
Location Md.

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Pleasant Ave

19 (a) MAR 13 1948 (Date rec'd by registrar) (b) [illegible] Wilson (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/11 1948, at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11/48 1948 to 3/11 1948, and that I last saw he alive on 3/11 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
Autopsy?

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature William Garner M.D.
Address 1514 Division St Date signed 3/12/48

VS 150

61171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 61171

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 524 Johanson St.
(If rural give location)
(e) Citizen of foreign country? I (Yes or No)
If yes, name country

3 (a) FULL NAME Purnell Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	N	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1943

8. AGE: Years	Months	Days	If less than one day
5			hr. min.

9. Birthplace MD
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Baily
13. Birthplace MD.

MOTHER
14. Maiden Name Henretta Baily
15. Birthplace MD.

16 (a) Informant Frank Baily
(b) Address 524 Johanna St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 15th (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Mt Winans

18 (a) Funeral director Clary O Wilson
(b) Address 1000 Brantleyan.

19 (a) MAR 13 1948 (Date rec'd by registrar) (b) Interring for Wilson Mortician

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10 1948 at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 1948 to 3/10 1948 and that I last saw h[illegible] alive on 3/10 1948.

Immediate cause of death
Lobar Pneumonia
Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Lobar Pneumonia RUL

of autopsy:

Duration
6 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. Garnes

Address 1514 Division Date signed 3/12/48 (M. D.)

JT X

1172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G61172

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 N. Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Barnes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace St marys co. md (Town, county, and state)
10. Usual Occupation Junk man
11. Industry or business For self

FATHER
12. Name William Henry Barnes
13. Birthplace St marys co. md

MOTHER
14. Maiden Name Ellen Hawkins
15. Birthplace Charles Co. md

16 (a) Informant Mary Kennedy
(b) Address 1238 St matthews St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 13-1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley ave

19 (a) MAR 13 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1948 at 4 55 PM

21. I certify that I took charge of the remains described above, held an Autop. + Ins (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Myocardial Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earle Ryan M.D. (Medical Examiner)
Date signed 3-8-48

VS 181

1173 / BALTIMORE CITY HEALTH DEPARTMENT ✓ 46-1173 Registered No.

CERTIFICATE OF DEATH • 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) All Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 832 Greenmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph J. THOMPSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Mary Compson

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 3-15-1895

8. AGE: Years	Months	Days	If less than one day
52	11	26	hr. min.

9. Birthplace Balto. md (Town, county, and state)

10. Usual Occupation Handy man

11. Industry or business

FATHER 12. Name William P. Thompson

13. Birthplace Canada

MOTHER 14. Maiden Name Helen Citison

15. Birthplace Balto Co. md

16 (a) Informant Mary Thompson

(b) Address 832 N. Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 15-1948 (month) (day) (year)

(c) Cemetery or crematory Balto. Nat. Cem.

Location Balto. md

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Bolton ave

19 (a) MAR 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1948 at 7 40 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D. Medical Examiner.

Date signed 3/10/48

VS 181

X

G61174 Frantzeskakis ✓ G61174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 876

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd Calvert St.
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Connecticut County
(c) City or town Waterbury
(If outside city or town limits, write RURAL and give town)
(d) Street No. 79 Franklin St.
(If rural give location)
(e) Citizen of foreign country? ... (Yes or No)
If [illegible] give name of country) John G. Frantzeskakis

3 (a) FULL NAME John G. Frantzis (JOHN G. FRANTZIS)
(b) If veteran, name war
3 (c) Social Security Account No. 046-12-9892

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Bella Frantzis (Maiden)
6 (c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) April 26, 1894
8. AGE: Years 53 | Months 10 | Days 3 | If less than one day ... hr. ... min.
9. Birthplace Greece (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name George J. Frantzis
13. Birthplace Greece

MOTHER
14. Maiden Name Anna Scandalis
15. Birthplace Greece

16 (a) Informant Hospital Record
(b) Address Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-48 (month) (day) (year)
(c) Cemetery or crematory Pine Grove
Location Waterbury - Conn.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (E. F. [illegible] SON) 100 N. NORTH AVENUE

19 (a) ... (b) ... (Date rec'd by registrar) ... Registrar

MAR 14 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-13-48 19 ..., at 10:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 29 1948 to Mar 13 1948, and that I last saw him alive on 3-13 1948.

Immediate cause of death	Duration
Diaphragmatic paralysis	11 days
Due to Paralysis of Phrenic nerve	11 days
Due to Following bilateral stellate ganglionectomy	11 days
Other Conditions Retinal hemorrhage — 5 yrs; Hypertensive cardiovascular disease — 15 yrs	

(Include pregnancy within 3 months of death)

Date of operation 3-2-48
Major findings of operation: ...
Autopsy: not permitted

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? ... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ... (Specify type of place)
(e) Means of injury ...
23. Signature J. A. Gregory, Jr., M. D.
Address Union Memorial Hosp Date signed 3-13-48

VS 150

CORRECT AGE IS [illegible] ... [illegible] ... [illegible]

661175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 661175

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15 E Montgomery St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 E Montgomery St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Heyman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Samuel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Abraham ?
13. Birthplace Russia

MOTHER
14. Maiden Name Unkown
15. Birthplace Russia

16 (a) Informant Nathan Heyman
(b) Address 15 E Montgomery St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 14, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Washington Road Cemetery
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date rec'd by Registrar) (b) Registrar, M.D.
MAR 14 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1948 at 6 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1948 to March 13 1948 and that I last saw him alive on March 13 1948

Immediate cause of death Myocarditis arterio sclerosis coronary occlusion — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Kadin M. D.
Address 2306 Eutaw Pl Date signed 3-13-48

X

G61176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46M

G61176 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2306 Wichita Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2306 Wichita Ave
(If rural give location)
Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Esther Goldberg

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Samuel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 65 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Moses
13. Birthplace Russia

MOTHER 14. Maiden Name Shirley
15 Birthplace Russia

16 (a) Informant Samuel Goldberg
(b) Address 2306 Wichita Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-14-48 (month) (day) (year)

(c) Cemetery or crematory
Location Hebrew Herring Run

18 (a) Funeral director Jacob Lavin Inc
(b) Address 260 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 14 1948

VS 150

MEDICAL CERTIFICATION √o

20. DATE OF DEATH 3-14-1948, at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1942 to March 14 1948.
and that I last saw her alive on March 13, 1948.

Immediate cause of death Duration

Carcinoma G.I. tract. about 1½ yrs

Due to —

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan H. Shpritz, M.D.

Address 1810 Eutaw Pl. Date signed 3/14/48

Kentucky for Williamsburg

X

G61177 ✓ G61177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 117a

G61177

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline
(c) Hospital or institution: St Joseph's
(d) Length of stay in hospital or inst. (~~yrs., months~~ days) 9
(e) Length of stay in Baltimore (yrs., ~~months~~ days) 69

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 E Lafayette (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph George Kreuzer (Joseph G. Kreuzer)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-12-1188

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Carrie Brommell

6 (c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.) 11/22/78

8. AGE: Years 69 | Months 3 | Days 20 | If less than one day ###### min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Shipping clerk

11. Industry or business Maryland Biscuit Co.,

FATHER
12. Name Caspar Kreuzer
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Getz
15. Birthplace Germany

16 (a) Informant Mrs. Gustave A. Wetzel (Sister)
(b) Address 1504 E. Lafayette Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12, 1948 at 2p M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/8/48 to 3/12/48 and that I last saw h[illegible] alive on 3/12/48

Immediate cause of death: Hemorrhage Acute — Duration: Recurrent
Due to: Gastric ulcer
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: Gastric ulcers

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. H. Barley
Address 1400 Caroline Date signed 3/12/48

VS 130

X

G61178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44B

G61178 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4007 Belview Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4007 Belview Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Wesley Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	M

6 (b) Name of husband or wife Amelia E. Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1880

8. AGE:	Years	Months	Days	If less than one day
	67	4	9	hr. min.

9. Birthplace Fort Wayne Ind.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name	William Jones
13. Birthplace	London, England
MOTHER 14. Maiden Name	Sarah Weldon
15. Birthplace	Liverpool, England

16 (a) Informant Amelia Jones
(b) Address 4007 Belview Ave

17 (a) Burial (b) Date thereof 3-15-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Lorman Boyer
(b) Address 5005 Park Heights Ave

19 (a) (b)
(Date received by registrar) Washington, D.C.

MAR 16 1948

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12, 1948, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 2 1948 to MAR. 12 1948
and that I last saw HIM alive on MARCH 4 1948

Immediate cause of death	Duration
Hodgkins Disease	2-4/12
Due to	
Due to	
Other Conditions GENERALIZED ARTERIO-SCLEROSIS	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jeanette K. Hopkins, M.D.
M. D.

Address 5528 Park Ave Date signed 3/1/48

Correct age is especially important if under 1 year or over 100

G61179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G61179
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2604 Francis St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Philadelphia
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2529 Island Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Leslie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1884

8. AGE: Years	Months	Days	If less than one day
64	-	14	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Kilpatrick
13. Birthplace Md ?

MOTHER
14. Maiden Name ?
15. Birthplace Md

16 (a) Informant Mrs. Joseph Freyman
(b) Address 2529 Island Rd.

17 (a) Removal (b) Date thereof 3-14-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Peace
Location Philadelphia Pa.

18 (a) Funeral director Wm. J. Tickner & Son
(b) Address North & Pennsylvania Ave, Baltimore Md

MAR 14 1948 (b) Huntingtown Williams, Md
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Mar. 1948, at 6.15 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D.
Medical Examiner.
Date signed 13 Mar. 48

VS 181

G61180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 (Registered No.) G61180

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 509 N. Curley Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 509 N. Curley Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ERNEST OLSZEWSKI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Helen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1867

8. AGE: Years	Months	Days	If less than one day
80	9	11	hr. min.

9. Birthplace Polkowo, Poland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Frank Olszewski
13. Birthplace Polkowo, Poland

MOTHER
14. Maiden Name Stanislawa Ukanowska
15. Birthplace Polkowo, Poland

16 (a) Informant Mrs. Elizabeth Hebrank
(b) Address 3201 E. Leverton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Road

18 (a) Funeral director M. F. Sadowski & Sons
(b) Address 1808 Eastern Avenue

MAR 14 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-12 1948, at 11A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-5 1948 to 3-12 1948 and that I last saw h alive on 3-12 1948.

Immediate cause of death	Duration
Myocardosis	
Due to arteriosclerotic [illegible]	
Due to Generalized Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John J Gorsuch M. D.
Address 147 E Eastern Ave Date signed 3-12-48

VS 150

CORRECT USE IS especially important

661181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 661181

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17 N. Carey St
(c) Hospital or institution: Good Samaritan Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 554 N. Macken St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida Nutt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widow

6 (b) Name of husband or wife Henry Nutt.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Gloucester Co. Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business Unemployed

FATHER
12. Name Aaron Lewis
13. Birthplace Va.

MOTHER
14. Maiden Name Mollie Baytop.
15. Birthplace Va.

16 (a) Informant Thomas Kelly
(b) Address 1113 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn Md

18 (a) Funeral director Leroy Williams
(b) Address 1000 Brantly Ave.

19 (a) (b) Registrar

DEATH (Date rec'd by Registrar) MAR 14 1948

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1948, at 8 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 11 1948, to March 11 1948, and that I last saw h.r alive on 3/11 1948.

Immediate cause of death	Duration
Carcinoma of Breast with Generalized	
Due to metastasis	
Due to	
Other Conditions Fract. Rt Elbow	1 mo.

(Include pregnancy within 3 months of death)
Date of operation Summer 1947
Major findings of operation: Ca of Breast (Left)
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Helen Mupperman
Address 21 N. Carey Date signed 3/15/48

COPIES NOT IN DUPLICATE WILL BE REJECTED

G61182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

✓ G61182 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 774 Bradley St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 774 Bradley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adaline Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Cd	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace Baltimore Md.
(Town, county and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name George Insley
13. Birthplace Md.

MOTHER
14. Maiden Name Henretta Insley
15 Birthplace Md

16 (a) Informant Edna Jones
(b) Address 774 Bradley St.

17 (a) Burial (b) Date thereof Sept 15-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Zion Dom
Location Baltimore Md

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Pulaski ave

19 (a) (b)
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1946 at 9:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1946 to Mar 11 1946
and that I last saw her alive on Mar 11 1946

Immediate cause of death Cerebral hemorrhage
Due to Hypertension Heart disease

Duration
2 days

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Greene M. D.
Address 75 W Eager St Date signed 3/13/46

Thurlington Williams Registrar

661183 ✓ ✗ 661183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. _____

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N Ellwood Ave.
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTIMORE
(c) City or town BALTIMORE RURAL
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~100 N Ellwood Ave~~ 2804 MICHIGAN Ave (Number and street or R.F.D. route)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country —

3 (a) FULL NAME HARRY P BARRETT

3 (b) If veteran, name war _____
3 (c) Social Security Account No. 220-07-9682

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife BARBARA BARRETT
6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) MAY-4-1882

8. AGE: Years 65 | Months 10 | Days 4 | If less than one day _____ hr. _____ min.

9. Birthplace BALTO MD (Town, county, and state)

10. Usual Occupation BARTENDER

11. Industry or business —

FATHER
12. Name _____
13. Birthplace _____

MOTHER
14. Maiden Name _____
15. Birthplace _____

16 (a) Informant ROSA M L BARRETT
(b) Address 100 N ELLWOOD ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3 15 48 (month) (day) (year)
(c) Cemetery or crematory LORRAINE PARK CEM
Location _____

18 (a) Funeral director THOS J KENNY INC
(b) Address HOLLINS & PENNSYLVANIA AVES

19 (a) 1948 (Date rec'd by registrar) (b) _____ Registrar

VS 150

Transcription for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/12 1948, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5 1948 to 3/12 1948.
and that I last saw h_____ alive on _____ 19____.

Immediate cause of death	Duration
Rt hemiplegia	2 hrs
Due to Hypertension	2 yrs
Due to Chronic myocarditis	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation _____
Major findings of operation: _____
of autopsy: _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide _____
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur?: _____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Chas Calas M. D.
Address 4 N Fulton Ave Date signed _____

correct age is especially important.

G61184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G61184

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 28-2
(c) Hospital or institution: 4508 Wentworth Rd.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4508 Wentworth Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY LOUISE GOLIBART

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Jerome A. Golibart
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 15, 1870

8. AGE: Years 77 | Months 7 | Days 26 | If less than one day hr. min.

9. Birthplace: Baltimore Co., Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: William H. Harker
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Louise Carmichael
15. Birthplace: Balto., Md.

16 (a) Informant: Mrs. Vernon A. Bolte, Sr.
(b) Address: 4508 Wentworth Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/48 (month) (day) (year)
(c) Cemetery or crematory: Holy Family Cem.
Location: Harrisonville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) MAR 14 1948 (b) Huntington for Williamsport, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11, 1948, at 3:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 27 1936, to March 11 1948
and that I last saw her alive on March 10 1948.

Immediate cause of death	Duration
1) Arterio-Sclerotic Cardio-Vascular Disease	10 yrs.
Due to	
Due to Hypertrophied Arterio Sclerosis	
Other Conditions Chronic Asthma	40 yrs.?

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: -
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl L. Chambers M. D.
Address 4108 Liberty Hts Date signed 3/13/48

VS 150

61185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181

Registered No. 061185

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14-2
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 months
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 618 Pitcher St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mary Sennas

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 3, 1866
8. AGE: Years 81 | Months 6 | Days 7 | If less than one day hr. min.
9. Birthplace Waldolf, Charles Co., Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Alfred Gross
13. Birthplace Waldolf Charles Co., Md.

MOTHER
14. Maiden Name Sophie Adelen
15. Birthplace Waldolf Charles Co., Md.

16 (a) Informant Mrs. Estelle Farmer
(b) Address Waldolf Charles Co., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/'48 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Baltimore, Md.

18 (a) Funeral director Joseph L. Russ
(b) Address 1200 McCulloh St.

19 (a) Filed [illegible] (Date received by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-10-'48 at 8 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5-'48 19__ to 3-10-1948 and that I last saw h[illegible] alive on 3-10 19 48

Immediate cause of death: Senility. Senile Dementia. Gangrene of left foot and leg.
Due to: 1st and 2nd degree burns of left leg.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 2-11-'48.
Major findings of operation: Gangrene of left foot & leg.
of autopsy: None.

Duration

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accidental
(b) Date of occurrence 1-3-'48 (?) at (?) M.
(c) Where did injury occur? 618 Pitcher St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Clothes became ignited from Gas Stove in Home. Not Afire

23. Signature Howard J. Haggerty, M.D. 113
Address Provident Hosp. Date signed 3-12-'48 M. D.

Correct age is especially important if deceased was under one year or one day

VS 150

1428 Kingsway Rd
1186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 651186

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5511 Groveland Ave.
(c) Hospital or institution: 28-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5511 Groveland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Oliver Washington Mangum

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 218-09-9341A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Lillie May
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 27, 1868

8. AGE: Years	Months	Days	If less than one day
79	10	14	hr. min.

9. Birthplace Prince George Co. Md. (Town, county, and state)
10. Usual Occupation Balto. Transit Co.
11. Industry or business Shop Man

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Oliver Talbott Mangum
(b) Address 5511 Groveland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15-48 (month) (day) (year)
(c) Cemetery or crematory Morgan Chapel
Location Woodbine Maryland

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave.

19 (a) MAR 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1948 at 11 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1941 to March 11 1948 and that I last saw him alive on March 11 1948

Immediate cause of death	Duration
(a) Coronary occlusion	1 hr
Due to (b) Hypertension C-V disease	10 yrs.
Due to	
Due to	
Other Conditions Generalized arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. A. Krenzer
Address 1428 Kingsway Date signed 3-15-48

correct age is especially important

VS 150

61187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

Registered No. 61187

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 454 E. Fort Ave
(c) Hospital or institution: 24-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 454 E. Fort Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lola Mielke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or divorced
fem.	white	Widowed

6 (b) Name of husband Ernest E. Mielke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 17th 1873

8. AGE: Years	Months	Days	If less than one day
75	0	26	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name George Lindner
13. Birthplace Germany

MOTHER
14. Maiden Name Eva Ephler
15. Birthplace Germany

16 (a) Informant Ernst E. Mielke
(b) Address 454 E. Fort Ave

17 (a) Burial (b) Date thereof 3/17/48
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) Date rec'd by Registrar MAR 15 1948 (b) Lentington for Williams M.D.

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/13 1948, at 10:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1 1948, to 3/13/ 1948, and that I last saw h[illegible] alive on 3/13/ 1948

Immediate cause of death Stokes Adams Syndrome — Duration 2½ mths.

Due to Coronary sclerosis

Due to Arteriosclerosis

Other Conditions Aortic Stenosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Weinberger M. D.
Address 912 Brooks Lane Date signed 3/14/48

G61188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G61188 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12-4
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 East Twentieth St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norman B. Gwynn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar 1879

8. AGE: Years	Months	Days	If less than one day
69 68	-		hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Gwynn
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Virginia T. Riddick
15. Birthplace Smithfield Va.

16 (a) Informant Mrs Read
(b) Address 320 E. 20th St.

17 (a) Burial (b) Date thereof 3/17/48
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 MAR 15 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/13/48, 19, 8:12 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy/ Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis, M.D.
Medical Examiner.
Date signed 3/14/48

VS 151

61189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 61189

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Levindale 21-17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES BENDER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years: 62 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name not known
13. Birthplace Russia

MOTHER
14. Maiden Name not known
15. Birthplace Russia

16 (a) Informant
(b) Address Levindale

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15-48 (month) (day) (year)
(c) Cemetery or crematory Location Hebrew Mt Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 2160 Eutaw Place

19 MAR 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-14 1948, at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1941 to 3-14 1948 and that I last saw h(e) alive on 3-14 1948.

	Duration
Immediate cause of death: Coronary thrombosis	
Due to: arteriosclerosis	
Due to:	
Other Conditions: Diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Vogel M. D.
Address Levindale Home Date signed 3-14-48

Correct age is especially important

VS 150

94a

61190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51 B ✓

Registered No. G61190

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 S. Streeper Street
(c) Hospital or institution: 1-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 514 S. Streeper Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT JULIUS MORITZ

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 212-18-4862

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emma C. Moritz

6 (c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1866

8. AGE: Years 81 | Months 4 | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business City Fire Dep't

FATHER
12. Name ? Moritz
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina ?
15. Birthplace Germany

16 (a) Informant Mrs. Emma C. Moritz
(b) Address 514 S. Streeper Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/48 (month) (day) (year)
(c) Cemetery or crematory First Evangelical Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENR Y SANDER & SONS, INC
(b) Address NORTH AVE., & BROADWAY

19 (a) MAR 15 1948 (Must not be filled in by Registrar) (b) Huntington, Indiana
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11, 1948, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to March 1948 and that I last saw h[illegible] alive on 3-11- 1948

Immediate cause of death	Duration
Carcinoma of prostate Gland	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene Zeller, M.D.
M. D.

Address 2739 Eastern Ave Date signed 3/12/48.

VS 150

1191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 65191

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 224 St. Helena Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Schuler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Louis Schuler
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1868

8. AGE: Years	Months	Days	If less than one day
79	4	6	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frederick ? ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant John Smith
(b) Address 66 Kinship Road, Dundalk, Md.

17 (a) Burial (b) Date thereof March 15, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Blvd.

18 (a) Funeral director Roland Litzelman
(b) Address 2112 Dundalk Ave.

19 MAR 15 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1948 at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 9 1948 to Mar. 11 1948 and that I last saw her alive on Mar. 11 1948

Immediate cause of death Respiratory Failure — Duration 1 Day

Due to Intracerebral hemorrhage left side — 2½ Days

Due to Hypertensive cardio-vascular disease — years

Other Conditions Contributing Terminal Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.
Address South Balto Gen Hosp Date signed Mar 12

correct age is especially important

VS 150

1192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. 61192

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 813 N Fulton Ave
(c) Hospital or institution: 16-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs 8 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 813 N Fulton Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country —

3 (a) FULL NAME Fannie McKinney Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	Widowed

6 (b) Name of husband or wife W. O.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1874

8. AGE: Years	Months	Days	If less than one day
74	-	7	hr. min.

9. Birthplace Maldeny Va (Town, county, and state)
10. Usual Occupation Teacher
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant William N. Carter
(b) Address 813 N. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/1948 (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Hampton Va

18 (a) Funeral director Geo. W. Stallard
(b) Address 1631 Pennsylvania Ave

19 (a) MAR 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/14 1948, at 3:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to 3/14 1948, and that I last saw him alive on 3/14 1948

Immediate cause of death Chronic Parenchymatous Nephritis — Duration: July 1946

Due to — Duration:

Due to — Duration:

Other Conditions Generalized Arteriosclerosis, Mitral Insufficiency, Arteriosclerosis (Include pregnancy within 3 months of death) — Duration: 6 mos

Date of operation none

Major findings of operation: —

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph L. Manning M.D.
Address 1424 E Monument St Date signed 3/15/48

Correct age is especially important

VS 150

61193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 61193

1. PLACE OF DEATH:
(a) Baltimore City, Maryland X
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital 8-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 39 days
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3427 Woodstock Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) **FULL NAME** Albert Edward Parlett

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-5128

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Dolores Catherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-26-05

8. AGE: Years	Months	Days	If less than one day
42	6	17	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Beth. Steel

FATHER
12. Name ALBERT H. PARLETT
13. Birthplace BALTIMORE

MOTHER
14. Maiden Name JESSIE BALLAUF
15. Birthplace BALTIMORE

16 (a) Informant MRS. ALBERT PARLETT
(b) Address 3427 Woodstock AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount Ce
Location

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St.

19 (a) Date received by local registrar MAR 5 1948 (b) Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-12 1948, at 5:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-2 1948 to 3-12 1948, and that I last saw him alive on 3-12 1948.

Immediate cause of death	Duration
Chronic uremia	
Due to Chronic glomerulo-nephritis	
Due to Hypertensive-cardio-vascular renal disease	
Other Conditions Bronchopneumonia (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy Chronic glom-neph: Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Joseph Krejci M. D.
Address 1400 N. Caroline St. Date signed 3-12-48

X

61194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G61194

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 13-8
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 21 dy

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3544 Poole St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edson Mary A

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife George H
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Alberton Md (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Louis Covey
13. Birthplace unknown

MOTHER 14. Maiden Name Catherine Burns
15. Birthplace Ellicott City

16 (a) Informant George H Edson
(b) Address 3544 Poole St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 17 48 (month) (day) (year)
(c) Cemetery or crematory St Marys
Location Laurel Md

18 (a) Funeral director Frank H Seitz
(b) Address 814 N 36th St

19 MAR 15 1948 (Date rec'd by registrar) (b) Catonsville, Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 13 1948 at 2 35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-22 19 48 to 3-13 19 48, and that I last saw h. er alive on 3-13 19 48

Immediate cause of death	Duration
Recurrent Carcinoma of the recto-sigmoid,	1 ½ yrs
Due to post-operative	
Due to	
Other Conditions Uremia from metastatic blockage of ureters (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mary D. Dan M. D.
Address Union Dep Date signed 3-13-48

VS 190

61195 G61195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St & Linden Ave
(c) Hospital or institution: Maryland General Hospital 13-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3614 Paine Rt.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Emory Spencer

3 (b) If veteran, name war | (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE:

Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Carroll Co Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name James Spencer
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Wm C Spencer
(b) Address 3308 Elm Ave

17 (a) Burial (b) Date thereof 3 15 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Marys Hampden
Location Baltimore Md

18 (a) Funeral director Frank W Sachs
(b) Address 814 N 36 St

19 (a) MAR 15 1948 (b) Thurlington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 Mar 1948, at 3.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7 Mar 1948 to 12 Mar 1948 and that I last saw h. alive on 12 Mar 1948.

Immediate cause of death	Duration
Bronchogenic carcinoma of right lung	2
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Allan Spies M. D.
Address Md. Gen. Hosp. Date signed 12 Mar 48

VS 153

61196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92c

Registered No. G61196

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 309 N. Central Ave
(c) Hospital or institution: 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 309 N. Central Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward B. LECATO

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	MARRIED

6 (b) Name of husband or wife MATILDA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 4. 1883

8. AGE: Years	Months	Days	If less than one day
65	-	8	hr. min.

9. Birthplace VA.
(Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business

FATHER
12. Name Edward Lecato
13. Birthplace VA.

MOTHER
14. Maiden Name CLARA ?
15. Birthplace VA.

16 (a) Informant MATILDA LECATO
(b) Address 309 N. CENTRAL AVE

17 (a) BURIAL (b) Date thereof 3-16-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MT. CALVARY
Location A.A. County, Md.

18 (a) Funeral director Joseph G. Locke
(b) Address 1304 N. Central Ave

19 (a) MAR 15 1948 Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 12 1948 at 11 35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3 1947 to March 12 1948 and that I last saw h— alive on 3/12 1948

Immediate cause of death: Coronary Occlusion & Arteriosclerosis — Duration 6 Mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature H. D. Hatcher

Address 17 W. 7th Ave Date signed 3/13/48

VS 150

G61197 Bethune ✓ G61197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1579

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 17-2
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1031 Argyle Ave. (If no street number give descriptive location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John A. Bethune

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1934

8. AGE: Years	Months	Days	If less than one day
13	9	9	hr. min.

9. Birthplace Sumpter, S. C. (Town, county, and state)

10. Usual Occupation School boy

11. Industry or business

FATHER
12. Name John A. Bethune
13. Birthplace S. C.

MOTHER
14. Maiden Name Mary Powell
15. Birthplace S. C.

16 (a) Informant Mrs Rohina Wilson
(b) Address 1031 Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/48 (month) (day) (year)
(c) Cemetery or crematory
Location Sumpter, S. C.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave

19 (a) MAR 15 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1948 at 5:30 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Megacolon (congenital)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D. Medical Examiner.
Date signed 3-13-48

VS 191

X

61198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

Registered No. 61198

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1-2
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Butto (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 or 7 Millon ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Richards
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Ethel
6 (c) If alive, give age ✓ Years
7. Birth date of deceased (mo., day, yr.) 3-10-83
8. AGE: Years 65 | Months 2 | Days | If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business
12. Name Joseph Richards (FATHER)
13. Birthplace Md
14. Maiden Name Emma Eppinger (MOTHER)
15. Birthplace Md
16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 15-48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem.
Location
18 (a) Funeral director John L. Miller
(b) Address 2331 Jefferson St.
19 (a) MAR 15 1948 (Date rec'd by registrar) (b) [illegible] Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-17-1948 at 4:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 21 Feb 1948 to 12 Mar 1948 and that I last saw h[illegible] alive on 12 Mar 1948.

Immediate cause of death: Bronchopneumonia — Duration 3 d.
Due to: Thrombosis left Iliac Vein — 3 wks
Due to: Fracture Rt Tibia + fib[illegible] — 3 M.
Due to:
Other Conditions: C N S syphilis. — 11 yrs.

(Include pregnancy within 3 months of death)
Date of operation None.
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 42
(a) Accident, suicide, or homicide acc.
(b) Date of occurrence 10-21-47 at 3:20 P M
(c) Where did injury occur? Orleans St. x Milton Ave. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public (Specify type of place) While at work? no
(e) Means of injury Pedestrian struck by auto
23. Signature Arthur B. Kemp M. D.
Address Johns Hopkins Date signed 3/17/48

(To be approved by M. E.) Herbert H. Kammer for Thomas J. Mackie, M.D.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61199 ✓ 94a G61199 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave + Madison St.
(c) Hospital or institution: Maryland General Hosp 15-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5½ hr
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3423 Monddawmin Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Charles R Brown

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 215-01-8858

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 16. 1886

8. AGE: Years 61 | Months 4 | Days 28 | If less than one day hr. min. 29

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation OFFICE MNGR.

11. Industry or business ATT. Plumbing Supply

FATHER 12. Name JOHN H. BROWN

13. Birthplace A. A. Co., MD.

MOTHER 14. Maiden Name GEORGIANA SHIPLEY

15. Birthplace Balto., MD.

16 (a) Informant JOHN H. BROWN

(b) Address 2303 Rosyln Ave

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/16/48 (month) (day) (year)

(c) Cemetery or crematory LOUDON PARK

Location BALTIMORE, MD.

18 (a) Funeral director Wm J. Tucker & Sons

(b) Address BALTIMORE MD.

19 (a) MAR 15 1948 (Date rec'd by registrar) (b) Interment for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1948, at 12 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 13 1948 to Mar 14 1948, and that I last saw him alive on March 13 1948.

	Duration
Immediate cause of death Cardiac † Respiratory failure	
Due to Coronary Thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature O. Jane Hunt M. D.

Address Maryland Gen Hosp Date signed 3-18-48

VS 153

X

1300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 111c

Registered No. 66200

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27-17
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3339 AVONDALE AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SALISBURY SILAS SAFFELL

3 (b) If veteran, name war WW II

3 (c) Social Security Account No. 220-20-6300

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife DOROTHY F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 14, 1913

8. AGE: Years 34 | Months 6 | Days 0 | If less than one day hr. min.

9. Birthplace ALEXANDRIA, VA.
(Town, county, and state)

10. Usual Occupation 2ND OFFICER

11. Industry or business U.S. MERCHANT MARINES

FATHER
12. Name HARRY L. SAFFELL
13. Birthplace Va.

MOTHER
14. Maiden Name LOVIALEE KERWIN
15. Birthplace Va.

16 (a) Informant MRS. DOROTHY F. SAFFELL
(b) Address 3339 AVONDALE AVE

17 (a) BURIAL (b) Date thereof 3/16/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory DRUID RIDGE
Location PIKESVILLE, MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTIMORE, MD.

19 (a) MAR 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14th March 1948, at 5 45 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 15th March 48

VS 151

X

G1201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G61201

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Denison St. 15-1
(c) Hospital or institution:
Crawford Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3119 Mondawmin Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE HENRY AMOS

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1868

8. AGE: Years 79 | Months 10 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name James N. Amos
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Laura J. Woods
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Grace P. Amos sister
(b) Address Homewood Apts. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/48 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 15 1948 (b) [illegible] Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1948 to March 12 1948 and that I last saw h. in alive on March 12 1948.

Immediate cause of death	Duration
Coronary Sclerosis	
Due to Senility & Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 3033 W Rost[illegible] Date signed 3/18/48

VS 130

X

61202 EL 117868

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

47c ✓

Registered No. 661202

1. PLACE OF DEATH: 26-7
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 612 S. Lehigh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME C
Charles Aichler

3 (b) If veteran, name war —
3 (c) Social Security Account No. 215-01-5481

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 14, 1908

8. AGE: Years	Months	Days	If less than one day
39	3	29	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John M. Aichler
13. Birthplace Maryland

MOTHER
14. Maiden Name Minnie Kues
15. Birthplace Maryland

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 16/48 (month) (day) (year)
(c) Cemetery or crematory Mt Lebanon Baltimore
Location
18 (a) Funeral director Philip Harvey Sons
(b) Address 2024 Eutaw St
19 MAR 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1948, at 2-15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 2 1948, to March 13 1948, and that I last saw him alive on March 13 1948.

Immediate cause of death	Duration
Massive Hemorrhage left upper lobe left lung	
Due to Squamous cell Undifferentiated Carcinoma left lung	
Due to	
Other Conditions Bronchopneumonia, right lung (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp Date signed 3-13-48

VS 199

X

61203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 131a

61203 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 24-2
(b) Street address 1219 Light Street
(c) Hospital or institution:
South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 629 E. Clement St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick H. Jenkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1874

8. AGE: Years	Months	Days	If less than one day
73	10	28	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Retired - B. O.

11. Industry or business

FATHER
12. Name Frederick H. Jenkins
13. Birthplace ?

MOTHER
14. Maiden Name Mathilda Riddle
15. Birthplace Penna

16 (a) Informant Fam. y
(b) Address Same

17 (a) B. (Burial, cremation, or removal) (b) Date thereof B-16-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Co. Md.

18 (a) Funeral director J. H. McCeney
(b) Address 1302 E. Fort Ave.

19 (a) MAR 15 1948 (Registered by registrar) (b) Huntington for Williamsport Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1948, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 6 1948, to Mar. 12 1948, and that I last saw him alive on Mar. 12 1948.

Immediate cause of death	Duration
Respiratory Failure.	12 hrs
Due to Acute congestive heart Failure.	6 mos
Due to Hypertensive cardio vascular disease	6 yrs
Other Conditions Nephrosclerosis Arteriosclerosis pulmonary edema. (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold H. Hillman M. D.
Address South Balto. Gen. Date signed Mar 17

VS 150

93D

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 61204

61204

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2015 W. Mulberry St
(c) Hospital or institution: 20-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 W Mulberry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Caroline Schultz
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Widowed

6 (b) Name of husband or wife John F. Schultz 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1886

8. AGE: Years	Months	Days	If less than one day
61	11	8	hr. min.

9. Birthplace Savage, Md. (Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name Gilbert Vollmerhausen
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Christina Leuck
15. Birthplace Germany

16 (a) Informant Arthur J. Schultz
(b) Address 2015 W. Mulberry St 3/15/48

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Frederick A. Cole
(b) Address 1300 W. Lombard St

19 MAR 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1948 at 2:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 1947 to 3/13 1948
and that I last saw her alive on 3/13 1948.

Immediate cause of death	Duration
Adenocarcinoma, left breast	
Due to	
Due to	
Other Conditions Essential hypertension (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide at M
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. Lauchlin Langfitt M. D.
Address 401 N. Payson St. Date signed 3/13/48

VS 150

1205
15-8019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. G61205

1. PLACE OF DEATH: 7-4
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 E. Eager, St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sadie Colbert.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Charles Colbert
6 (c) If alive, give age: 69 years
7. Birth date of deceased (mo., day, yr.): 12-8-93
8. AGE: Years: 54 Months: 3 Days: 7 If less than one day: hr. min.
9. Birthplace: Va. (Town, county, and state)
10. Usual Occupation: house wife
11. Industry or business

FATHER
12. Name: Neal Turner
13. Birthplace: Va.

MOTHER
14. Maiden Name: Margaret Steet
15. Birthplace: Va

16 (a) Informant: records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 19 48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary Cem.
Location: A. A. County Md

18 (a) Funeral director: Mrs. Robt. A. Elliott & Dy
(b) Address: 1129 N. Carlton St

19 (a) MAR 15 1948 (b) Huntington Williamsie, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March - 15 - 1948 at 3 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-24- 1948 to 3-15- 1948 and that I last saw her alive on 3-15- 1948.

Immediate cause of death: Resp. failure

Due to: Uremia

Due to: Chr. nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: M Busacke
Address: J. H. H. Date signed: 3-15-48 M. D.

VS 150

G61206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

185

Registered No. G61206

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10-2
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4hrs 45 Mts
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1243 E. Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Horace N. Mosed

(b) If veteran, name war: World War #2

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

(b) Name of husband or wife: Lucy Mosed

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 4, 1908

8. AGE: Years 39 | Months 4 | Days 9 | If less than one day ..... hr. ..... min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name John Mosed
13. Birthplace N. C.

MOTHER
14. Maiden Name Rosie McDew
15. Birthplace N. C.

16 (a) Informant Lucy Mosed
(b) Address 1600 W. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 7/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn National Cem
Location

18 (a) Funeral director Mrs Ruth A Elliott & Dgh
(b) Address 174 N. Carey St.

19 (a) MAR 15 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1948, at 2:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Gsd. Peritonitis Appendicitis

Other Conditions Operated upon for Pulmonary Infarction
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-12-48 at 9:30 P.M. 10/2
(b) Where did injury occur? 1300 Blk. Hampel Alley
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Gunshot wound

23. Signature Medical Examiner. M.D.

Date signed 3-13-48

VS 181

1207. BALTIMORE CITY HEALTH DEPARTMENT 108 Registered No. 661207

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14-2
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 McCulloh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bell Minor

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 18, 1898

8. AGE: Years 49 | Months 6 | Days 25 | If less than one day hr. min.

9. Birthplace Virginia (town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Flemings Minor
13. Birthplace Virginia

MOTHER
14. Maiden Name Nancy
15. Birthplace Virginia

16 (a) Informant Phyllis Cooper
(b) Address 1511 McCulloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cem
Location

18 (a) Funeral director Mrs Hattie R. Gilliard
(b) Address 229 N. Schroeder St.

19 (a) MAR 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12, 1948, at 12 05 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry), Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Thomas J. Mullen M.D. Medical Examiner.
Date signed 3/13/48

61208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G61208

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 55 days
(e) Length of stay in Baltimore (yrs., mos., or days): 55 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Va. (b) County:
(c) City or town: Whitestone
(If outside city or town limits, write RURAL and give town)
(d) Street No.: Lancaster County
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: WILLIS WILLIAMS

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Married

6 (b) Name of husband or wife: Edna Wormley
6 (c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): July 11, 1888

8. AGE: Years	Months	Days	If less than one day
59	8	1	hr. min.

9. Birthplace: Whitestone, Va.
(Town, county, and state)
10. Usual Occupation: Deckhand
11. Industry or business: Seafarer

FATHER
12. Name: Raleigh Williams
13. Birthplace: Whitestone, Va.

MOTHER
14. Maiden Name: Rachael Ball
15 Birthplace: Whitestone, Va.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/48 (month) (day) (year)
(c) Cemetery or crematory: Kalmarpock
Location: Kalmarpock, Va

18 (a) Funeral director: Geo. B. Kelson
(b) Address: 1303 Presstman St

19 (a) MAR 15 1948 (Date rec'd by registrar) Thurston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 12 1948, at 6:20A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 17 1948 to Mar. 12 1948, and that I last saw him alive on Mar. 12 1948.

Immediate cause of death	Duration
Infarction of lung due to embolus	One wk.
Other conditions: Arterio-	Unknown
Due to sclerotic heart disease with congestive failure	
Due to Arteriosclerosis, general	Unknown
Cardiac insufficiency	Unknown
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Stuart M. Sessoms
Stuart M. Sessoms, Asst. Surgeon M. D.
Address: US Marine Hospital, Balto, 11, Md. Date signed: 3/15/48

VS 15)

G61209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G61209 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 705 RESERVOIR ST.
(c) Hospital or institution: 13-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) /
(e) Length of stay in Baltimore (yrs., mos., or days) /

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 705 RESERVOIR ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country /

3 (a) FULL NAME Lester Gray Sampson

3 (b) If veteran, name war: WW # II

3 (c) Social Security Account No. 231-16-3958

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife CHARLOTTE K. SAMPSON

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/29/1916

8. AGE: Years	Months	Days	If less than one day
31	2	16	hr. min.

9. Birthplace MISKIMON, Va.
(Town, county, and state)

10. Usual Occupation INSPECTOR

11. Industry or business WESTERN ELECT.

FATHER
12. Name FRANKLYN K
13. Birthplace Va.

MOTHER
14. Maiden Name LILLIAN G COCKRELL
15. Birthplace Va.

16 (a) Informant MRS. CHARLOTTE K. SAMPSON
(b) Address 705 RESERVOIR ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/17/48 (month) (day) (year)
(c) Cemetery or crematory MORELAND MEM.
Location Balto Co. Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Baltimore, Md.

19 (a) MAR 5 1948 (Date rec'd by registrar) (b) Tentatively for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-1-48, 1948, at 9:25 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 3-5-48

VS 151

G61210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

G61210
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 509 W. Lexington (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Blanche Kamtman

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband ~~or wife~~: George F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-15-81

8. AGE: Years 66 | Months 8 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ? Kauffman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name ? Foreman
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Bernard Kamtman
(b) Address 14 St. Martins Rd. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/48 (month) (day) (year)
(c) Cemetery ~~Woodlawn~~ Parkwood Cem.
Location Balto. Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

VS 193

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-12-1948, at 9 20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-15-1948 to 3-12-1948, and that I last saw her alive on 3-12-1948.

Immediate cause of death	Duration
CARDIO-RESPIRATORY FAILURE	
Due to ARTERIOSCLEROTIC HEART DISEASE	
Due to	
Other Conditions CARCINOMA of STOMACH (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation: CARCINOMA of STOMACH
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley B. Klyanowicz M.D.
Address St. Joseph's Hosp. Date signed 3-15-48

937

G61211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55c

Registered No. G61211

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Sorrento Rd.
(c) Hospital or institution: Colonial Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County B. A. Co.
(c) City or town Jones Sta. B A Co.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph H. Frantum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Clara Bell Frantum
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 6-1870

8. AGE: Years	Months	Days	If less than one day
77	4	7	hr. min.

9. Birthplace B. A. Co. Md.
(Town, county, and state)
10. Usual Occupation Gas & Elec. Co.
11. Industry or business Retired

FATHER
12. Name Joseph H. Frantum
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Sewell
15. Birthplace Md.

16 (a) Informant Mrs. Dorothy Wagner
(b) Address Jones Sta. B A Co. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 / 17 / 48 (month) (day) (year)
(c) Cemetery or crematory Frantum family
Location Jones Sta. B. A. Co. Md.

18 (a) Funeral director E. Willis Lamoreaux
(b) Address 1063 W. Baltimore St.

19 (a) Typewritten Williams M.D. Registrar
(Date rec'd by registrar) MAR 15 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13- 1948 at 11P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-31- 1947 to 3-13 1948 and that I last saw him alive on 3-13 1948

Immediate cause of death: Carcinoma of Thyroid gland — Duration: Un Known

Due to: —

Due to: —

Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation Dec 1947

Major findings of operation: Carcinoma of Thyroid

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. L. Singewald M.D.

Address 1109 St Paul St Baltimore 2 Md Date signed 3-14-48

X

G61212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G61212

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 846 W. Lombard St.
(c) Hospital or institution: 18-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Md
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 500 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Stewart

3 (b) If veteran, name war 1 | 3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years 80 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name unknown
FATHER 13. Birthplace Unknown

MOTHER 14. Maiden Name "
MOTHER 15. Birthplace

16 (a) Informant Earl L Hess
(b) Address 715 Light St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/48 (month) (day) (year)
(c) Cemetery or crematory Glenwood
Location Wash DC

18 (a) Funeral director Earl L Hess
(b) Address 715 Light St Huntington Williams, MD

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/12/48 19 , at 9:30 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Hess M.D. (Medical Examiner)
Date signed 3/15/48

VS 181

X

G61213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

G61213 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 27-4
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3006 Gilston Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. O. Maude France or (Frang)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, (married) widowed, or divorced: married

6 (b) Name of husband or wife Peter J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 25-1878

8. AGE: Years 69 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Wm. Miller
13. Birthplace Md.

MOTHER
14. Maiden Name Ora K. Jordan
15. Birthplace Md.

16 (a) Informant Mrs Peter J. France
(b) Address 3006 Gilston Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto

18 (a) Funeral director J. Luck
(b) Address 530 S. Stafford St.

MAR 15 1948 (Date rec'd by registrar) (b) Washington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 11 1948, at 4:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 8 1948 to Mar 11 1948, and that I last saw h alive on Mar 11 1948.

Immediate cause of death peritonitis, toxemia — Duration

Due to Post-operative strangulated hernia & bowel resection

Due to

Other Conditions Cholecystitis & Cholelithiasis; Chr. colitis

(Include pregnancy within 3 months of death)

Date of operation Mar 9

Major findings of operation: Strangulated hernia & gangrenous bowel

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. C. Dewall Jr. M. D.
Address University Hosp. Date signed Mar 11

X

G61314

48-05451

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

160a

G61314
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline 7-4
(c) Hospital
St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 hr. 50 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 19 hr. 50 min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME McQuaige, Baby Boy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	SINGLE

6 (b) Name of husband or wife — — —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11, 1948

8. AGE: Years	Months	Days	If less than one day
			19 hr. 50 min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name James McQuaige
13. Birthplace N.C.

MOTHER
14. Maiden Name Louise Smith
15. Birthplace N.C.

16 (a) Informant James McQuaige
(b) Address 1011 Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Rd.

19 (a) 3-13-48 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12, 1948, at 7:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 11, 1948 to March 12, 1948 and that I last saw h[illegible] alive on March 12, 1948

Immediate cause of death Respiratory Failure

Due to Intracranial Hemorrhage

Due to Birth Injury

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Anthony F. DeLouise, M.D.
Address St. Joseph's Hosp. Date signed 3-15-48

VS 150

G61215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

113

Registered No. G61215

1. PLACE OF DEATH: 26-2
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4610 Furley Ave. 6 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** GARGIULO Frank

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife LOUISE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16 - 1892

8. AGE: Years	Months	Days	If less than one day
55	3	28 29	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Concrete Worker

FATHER
12. Name Joseph Gargiulo
13. Birthplace Italy

MOTHER
14. Maiden Name Michea Russo
15. Birthplace Italy

16 (a) Informant Mrs. Louise Gargiulo
(b) Address 4610 Furley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto.

18 (a) Funeral director L. D. Leyk
(b) Address 5305 Harford Rd.

19 (a) 5 1948 (Date received by registrar) (b) Registrar

Hemling & Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/15 1948, at 3 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/14 1948 to 3/15 1948 and that I last saw h/M alive on 3/15 1948.

Immediate cause of death	Duration
CARDIAC FAILURE	
Due to EMPHYSEMA	
Due to	
Other Conditions PROLAPSED HEMORRHOIDS (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Mary P. Porter M. D.
Address St. Jos. Hosp Date signed 3/16/48

VS 150

X

Dr. G61216 ✓ G61216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93)

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3303 Gibbons Avenue
(c) Hospital or institution: 27-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3303 Gibbons Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lillian B. Burke

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife John T. Burke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25, 1866

8. AGE: Years	Months	Days	If less than one day
81	8	18 19	hr. min.

9. Birthplace New York
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

MOTHER / FATHER
12. Name ?
13. Birthplace ?
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Linton O. Tewes
(b) Address 3303 Gibbons Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 MAR 15 1948 (Date rec'd by registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 1948 at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 17 1948 to March 14 1948.
and that I last saw her alive on March 13 1948.

Immediate cause of death	Duration
Bilateral Bronchopneumonia (Hypostatic Pneumonia)	4 days
Due to Chronic myocarditis with Auricular Fibrillation	3 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? none
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury none

23. Signature X. L. Leonardy M.D.
Address 5106 Harford Road Date signed 3/15/1948

VS 159

Dr. Lilienfeld
G61217

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 97

G61217
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706 E. Biddle Street
(c) Hospital or institution: 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706 E. Biddle Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Heltzel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Eliza Irene
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, ~~1870~~ 1871

8. AGE: Years	Months	Days	If less than one day
77 ~~78~~	1	26	hr. min.

9. Birthplace Penna.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Margaret Kehm
15. Birthplace Germany

16 (a) Informant Mr. Walter C. Heltzel
(b) Address 4711 Harford Road, #14

17 (a) Burial (b) Date thereof 3/16/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. P.,
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 MAR 15 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1948, at 10:34 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4 Mar 1948 to 13 March 1948 and that I last saw him alive on 13 March 1948.

Immediate cause of death	Duration
pulmonary edema	1 Day
Left sided failure	1
Congestive failure - ~~with~~ hrd.	2 weeks
Due to arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Lilienfeld M. D.
Address 714 E Preston Date signed 15 March

VS 150

X

61218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 61218

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address John Hopkins Hoo. 2
(c) Hospital or institution: 1-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 119 S Linwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Brush
(b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Stanislawa Brush
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) ?
8. AGE: Years 53 Months Days If less than one day hr. min.
9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Stanislaw Brush
13. Birthplace Poland ?

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Stanislawa Brush
(b) Address 119 S Linwood Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 17/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Baltimore
18 (a) Funeral director Fred W Ozazewski
(b) Address 1930 Eastern Ave
19 (a) MAR 15 1948 (Date rec'd by registrar) (b) [illegible] Washington Boulevard

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1948 at 11:55 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of Skull - Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-5-48 at 2/3 6:00 P M.
(b) Where did injury occur? 1607 Shakespeare St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Fell from wall to sidewalk

23. Signature [signature] M.D.
Medical Examiner.
Date signed March 17 48

VS 181

KONARSKI

61219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 61219

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 105 S. Washington St.
(c) Hospital or institution: 2-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 105 S. Washington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Magdalena Konarski

3 (b) If veteran, name war: N
3 (c) Social Security Account No. none

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Michael
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1880

8. AGE: Years 67 | Months 6 | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation house work
11. Industry or business

FATHER
12. Name William Dombrowski
13. Birthplace Poland

MOTHER
14. Maiden Name Ella ?
15. Birthplace Poland

16 (a) Informant John Konarski
(b) Address 105 S. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/48 (month) (day) (year)
(c) Cemetery or crematory Sac. Ht. of Jesus
Location German Hill Rd.

18 (a) Funeral director The Degnel Bros.
(b) Address 1600 E. Lombard St.

19 MAR 15 1948 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1948, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 8 1948 to Mar 13 1948, and that I last saw h.er alive on Mar. 13 1948

Immediate cause of death	Duration
Pulmonary Oedema	1
Due to Myocardial Degeneration	Life
Due to Hypertension	
Other Conditions Uppr Respiratory Infect	one mo

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Fleig, M.D.
Address 24 S. Bay Date signed March 15 1948

VS 150

61220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95 B

Registered No. G61220

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — 13-7 Dukeland
(b) Street address Rayner
(c) Hospital or institution West Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 months
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3625 Elm Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Hetrick
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Herbert J. Hetrick
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) August 8, 1890

8. AGE: Years 57 | Months 5 7 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Miller
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Herbert J Hetrick
(b) Address 3625 Elm Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Woodlawn Md

18 (a) Funeral director Geo L Beyer Jr
(b) Address 512 Hollins St

19 (a) MAR 15 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1948, at 11 40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 March 1948 to 12 March 1948 and that I last saw h. CR alive on 12 MARCH 1948

Immediate cause of death — Duration
Pulmonary Edema
Due to Heart Failure
Due to Rheumatic [redacted] ?
Other Conditions Heart Disease ?
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Matchar
Address W Fd Baltimore Jen Date signed 12 March

X

61221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G61221
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11-4
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 927 Morris alley (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Stewart

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years: 84 | Months | Days | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation 3

11. Industry or business 3

FATHER 12. Name 3
13. Birthplace

MOTHER 14. Maiden Name 3
15. Birthplace

16 (a) Informant 3
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director C. Hamlet
Address 940 Lexington

MAR 19 1948

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1948, at 1:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl Boyd M.D.
Medical Examiner.
Date signed 3-20-48

VS 181

61222

61222 JL - 13666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. _____

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 5-1
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County _____
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 423 Somerset St.
(If rural give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3 (a) FULL NAME Blanche Moore

3 (b) If veteran, name war _____ | 3 (c) Social Security Account No. _____

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife _____ 6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1895

8. AGE: Years	Months	Days	If less than one day
53	1	2	_____ hr. _____ min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Joseph Moore
13. Birthplace ?

MOTHER
14. Maiden Name Levinia ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location E. Halsted
18 (a) Funeral director 918 - Druid Hill Ave
(b) Address
19 MAR 15 1948 (Date rec'd by Registrar) (b) Huntington Woods

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 – 1948, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7 1936, to Feb. 5 1948, and that I last saw her alive on Feb. 5 1948.

Immediate cause of death	Duration
Acute Myocardial Infarction,	
Due to Coronary Arteriosclerosis	
Due to	
Other Conditions Arteriosclerosis Heart Disease	

(Include pregnancy within 3 months of death)

Date of operation _____
Major findings of operation: _____
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide _____
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature E. R. Scarborough M. D.
Address Balto City Hosp Date signed 3-13-48

X

VS 150

612223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 612223

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Pimlico Road
(c) Hospital or institution: 27-16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4702 Pimlico Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar L. Morissett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Gertrude Link
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 3 1884

8. AGE: Years	Months	Days	If less than one day
64	2	9	hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Elevator Work

11. Industry or business

FATHER 12. Name Edgar Morrisett

13. Birthplace Va

MOTHER 14. Maiden Name Rose Klinefelter

15. Birthplace Balto

16 (a) Informant Mrs Gertrude Morrisett

(b) Address 4702 Pimlico Road

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Mar 16/48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Balto

18 (a) Funeral director Leland Funeral Home

(b) Address 2008 Orleans St

MAR 15 1948 (Date rec'd by registrar) (b) Huntington Williamsville, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 12 1948, at 3 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to March 12 1948 and that I last saw h[illegible] alive on 3/11 1946.

Immediate cause of death	Duration
Arteriosclerotic Cardio Vascular Disease	3 years
Due to Coronary Thrombosis	3 years
Due to Cerebral Embolism and Cerebral Embolism	3 years 48 hours

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A A Weinstock M. D.
Address 4603 Park Heights Ave Date signed 3/12/48

VS 150

1224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937 ✓

Registered No. G61224

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 138 Rochester Place
(c) Hospital or institution: 1-2 ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 138 Rochester Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE M. KARMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Joseph F. Karman
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Jan 9, 1898

8. AGE: Years	Months	Days	If less than one day
50 58	2	5	hr. min.

9. Birthplace Baltikore, Md.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name William Jubb
13. Birthplace Maryland

MOTHER
14. Maiden Name Florence Gibson
15 Birthplace Maryland

16 (a) Informant Joseph Karman
(b) Address 138 Rochester Place

17 (a) Burial (b) Date thereof 3/17/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Colgate, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 (a) MAR 15 1948 (b) [illegible]
(Date received by registrar) (Registrar)

V3 151

MEDICAL CERTIFICATION

A

20. DATE OF DEATH March 14, 1948 9 , at 1:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/29/1947 to 3/14 1948, and that I last saw her alive on 3/13/1948

Immediate cause of death	Duration
Cerebral Hemmorrhage	6 Days
Due to Hypertension Coronis —	
Due to cerebral Hemm	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. Ethelbert F. Kierbronner M. D.
Address 1016 S Eutaw Date signed 3/15/48

X

1225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 61225

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St H-4
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 442 Tobman Ct. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Hoskins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/2/892

8. AGE: Years	Months	Days	If less than one day
56		12	hr. min.

9. Birthplace Salisbury N. C. (Town, county, and state)

10. Usual Occupation Bagger

11. Industry or business Davidson Chem Corp

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Samuel Hoskins (patient)
(b) Address 442 Tobman Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Cedar Hill Md

18 (a) Funeral director Adolphus Hailstock
(b) Address 918 Druid Hill Ave

19 MAR 15 1948 (Date rec'd by registrar) (b) Arrington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/14 1948 at 2.04 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/2 1948 to 3/14 1948, and that I last saw h[illegible] alive on 3/13 1948

Immediate cause of death Uremia — Duration 10 days

Due to Hypertension — Duration unknown

Due to

Other Conditions Hypertensive cardiovascular disease with heart failure — Duration 5 days
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature O. W. Hoffler

Address Provident Hospital Date signed 3/15/48

VS 150

61226 G.H. 117489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G61226

PLACE OF DEATH:

a) Baltimore City, Maryland

b) Street address 4940 Eastern Ave.

c) Hospital or institution: Balto. City Hospitals 9-9

d) Length of stay in hospital or inst. (yrs., mos., or days) 28 29 Days

e) Length of stay in Baltimore (yrs., mos., or days) 51 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1639 Aisquith ST. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

1. (a) FULL NAME: Margaret Craig (Margaret T.Craig)

(b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Edward P.Craig

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Jan. 6 - 1883

8. AGE: Years 65 | Months 2 | Days 8 | If less than one day ###### min.

9. Birthplace: Ireland (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER 12. Name: Jeremiah Craig

13. Birthplace: Ireland

MOTHER 14. Maiden Name: Margaret Owens

15. Birthplace: Ireland

16 (a) Informant: Records Balto. City Hospitals

(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/48 (month) (day) (year)

(c) Cemetery or crematory: New Cathedral

Location: Edmondson Avenue, Balto: Md.

18 (a) Funeral director: George J.Ruth, Inc.

(b) Address: 1735 Harford Avenue

19 (a) MAR 15 1948 (Date rec'd by registrar) (b) Beatrice for Williams M Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 14 - 1948, at 5.00AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2- 15 - 1948, to 3 - 14 - 1948, and that I last saw her alive on 3 - 14 - 1948.

Immediate cause of death: Carcinoma of Splenic Flexure of Colon Duration: Appox 2 yrs

Due to: Uremia and Multiple Metastasis

Due to:

Other Conditions: Arteriosclerotic Cardio-Vascular disease (Include pregnancy within 3 months of death)

Date of operation: 2/27/48

Major findings of operation: as above

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: Frank S. Lanata M.D.

Address: Baltimore City Hosp Date signed 3/14/48

VS 150

2227 48-1FP36

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No. 661227

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Gilmore
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 6½ hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Rural 8
(If outside city or town limits, write RURAL and give town)
(d) Street No. 31 Chandella Rd Balto Co.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Tyner

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. INFANT

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1948

8. AGE: Years | Months | Days | If less than one day 6 hr. 30 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

MOTHER / FATHER

12. Name Andrew Tyner

13. Birthplace Clarence, Pa.

14. Maiden Name Della Heaton

15. Birthplace Clarence, Pa.

16 (a) Informant Della Tyner

(b) Address 31 Chandella Rd. Balto Co.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Location Johns Hopkins Medical School MAR 9 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) MAR 15 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1948 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/2 1948 to 3/2 1948 and that I last saw her alive on 3/2 1948

Immediate cause of death Cardio respiratory failure — Duration

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Subaponeurotic hemorrhage Atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature D. F. Brumbaugh III

Address Franklin Square Hosp Date signed 3/2/48

Correct age is especially important if deceased was under one year or one day.

VS 150

61228 BALTIMORE CITY HEALTH DEPARTMENT Registered No. 61228

BC-48-06585 CERTIFICATE OF DEATH 159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hosp + Greene / Redwood
(c) Hospital or institution: University Hospital Balto, Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 alcock Rd # 21 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Shoemaker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age ~~Living~~ years

7. Birth date of deceased (mo., day, yr.) March 6, 1948

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation ~~infant~~

11. Industry or business

FATHER 12. Name William Clayton Shoemaker

13. Birthplace Friendsville, Md

MOTHER 14. Maiden Name Winifred McGann

15. Birthplace Pittsfield Mass.

16 (a) Informant mother of child.

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical School MAR 10 1948

18 (a) Funeral director

(b) Address Commissioner of Health

19 MAR 15 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 6 1948, at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3 - 4 1948 to 3 - 6 1948 and that I last saw him alive on 3 - 6 1948.

Immediate cause of death	Duration
respiratory and cardiac embarrassment	
Due to premature birth	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Romer M. D.

Address University Hosp Balto, Md Date signed 3-6-48

VS 190

X

Jezek ✓

C61229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

C61229

Registered No.

PLACE OF DEATH:
Baltimore City, Maryland
Street address 4709 Fairhaven
Hospital or institution: 2-5

Length of stay in hospital or inst. (yrs., mos., or days)
Length of stay in Baltimore (yrs., mos., or days) 52 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore 26
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4709 Fairhaven
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

1. (a) FULL NAME John Jezek (JEZEK) ✓

(b) If veteran, name war —

3 (c) Social Security Account No.

Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	wh	

(b) Name of husband or wife Margaret Jezek
6 (c) If alive, give age 66 years

Birth date of deceased (mo., day, yr.) Sept. 6th 1876

AGE: Years	Months	Days	If less than one day
71	05	7	hr. min.

4. Birthplace Lukodol Czechoslovakia (Town, county, and state)
10. Usual Occupation Bridge operator
11. Industry or business

12. Name John Jezek
13. Birthplace Czechoslovakia
14. Maiden Name Katherine Stransky
15. Birthplace Czechoslovakia

16 (a) Informant Wife
(b) Address 4709 Fairhaven

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 16 48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Baltimore Md

18 (a) Funeral director Enoch Pratt Loy
(b) Address 900 E Eastern Ave

19 (a) 5 1948 (Date rec'd by registrar) (b) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 13th 1948, at 6 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to 3 13 1948, and that I last saw h[illegible] alive on 3 12 1948.

Immediate cause of death	Duration
Coronary Thrombosis	3 11 48
Due to Coronary arteriosclerosis	2 days
Due to Generalized arteriosclerosis	
Other Conditions Bronchopneumonia (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. G. Summers M. D.
Address 1075 Pulaski Date signed 3/13/48

VS-8

X

G61230 ✓ G61230

GM. 108965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26-17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Year
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. NO Home
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patrick Holmes ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2 -1881

8. AGE: Years	Months	Days	If less than one day
66	11	9	hr. min.

9. Birthplace MD.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John
13. Birthplace England

MOTHER
14. Maiden Name Sarah Hews
15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3-16-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore National Forest Lawn
Location Hartford Ave. Baltimore
18 (a) Funeral director Charles F. Weill
(b) Address 1501 E. Fort Ave

19 (a) 3-5-1948 (b)
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 11 - 1948, at 7.15P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3 - 7 - 1947 to 3 - 11 - 1948, and that I last saw him alive on 3 - 11 - 1948.

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: none done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. T. Binford M. D.
Address Balt. City Hosp Date signed 3-12-48

VS 150

C61231

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 61

C61231 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2109 GREENMOUNT AVE
(c) Hospital or institution: 9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 GREENMOUNT AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME M. FRIEDRICKA DIERKER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife CHARLES DIERKER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace BALTO., MD. (Town, county, and state)
10. Usual Occupation M. HOME.
11. Industry or business

FATHER
12. Name WM. JOHN MARQUARDT
13. Birthplace GERMANY

MOTHER
14. Maiden Name — LEIGH
15. Birthplace GERMANY

16 (a) Informant MR. R. DRENNAN
(b) Address 2109 GREENMOUNT AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-15-48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location CITY

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREENMOUNT AVE & 22ND

19 (a) MAR 15 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-13-48 19 , at 6:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-28-48 19 , to 3/13/ 1948, and that I last saw h. alive on 3/12/ 1948

Immediate cause of death	Duration
Myocardial Insufficiency	4 days
Due to Myocarditis	
Due to Ludwig Carcinoma Tonsil Neck Region	
Other Conditions Diabetes Mellitus	17 Years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas F. Wolfe
Address 532 E 22nd St Date signed 3/15/48

VS 190

93E

232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G61232

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 302 S Exeter St.
(c) Hospital or institution: 3-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 53 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 302 S. Exeter St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Scolastica Annarella or Iannarelli

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: late Anthony

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13 1873

8. AGE: Years 74 | Months 11 | Days - | If less than one day hr. min.

9. Birthplace Cirasole Italy
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Enrico Fusco
13. Birthplace Italy

MOTHER
14. Maiden Name Arcangela
15. Birthplace Italy

16 (a) Informant Rosina Infussi
(b) Address 302 S. Exeter St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 16/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.

19 (a) MAR 16 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-13 1948 at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-10 1948 to 3-13 1948. and that I last saw her alive on 3-12 1948

Immediate cause of death: Coronary Thrombosis — Duration: 3 days

Due to: Arterio Sclerosis — Duration: 1 year

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. Fusco M.D.
Address 3 Medical Arts Bldg Date signed 3-15-48

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G61233
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N Carey St.
(c) Hospital or institution: Good Samaritan Home 8-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 N. Collington ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah E. Harvey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband or wife: John M. Harvey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 25th 1858

8. AGE: Years 90 | Months 0 | Days 19 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name (Unknown) Lanahan

13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Britt

15. Birthplace Balto. Md.

16 (a) Informant Joseph M. Harvey

(b) Address 5577 Ashbourne Rd.

17 (a) Burial (b) Date thereof 3/17/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London Park

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

19 (a) Date received by Registrar C 1948 Registrar

VS 150 —

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 14th 1948, at 5 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 1948 to March 14 1948 and that I last saw h. alive on March 14 1948

Immediate cause of death: Arteriosclerosis Cerebral Vessels — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stella Impresicio

Address 27 North Carey St Date signed 3/15/48 M. D.

Stella Impresicio

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. 661234

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3035 Pinewood Ave
(c) Hospital or institution: 27-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3035 Pinewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Melissa E. Pfeffer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~. Widowed

6 (b) Name of husband ~~or wife~~ John R. Pfeffer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29th 1865

8. AGE: Years 82 | Months 2 | Days 15/16 | If less than one day hr. min.

9. Birthplace Oakland Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER 12. Name Wm B. Beakman

13. Birthplace Carroll Co. Md.

MOTHER 14. Maiden Name Emily J. Stockdale

15. Birthplace Carroll Co. Md.

16 (a) Informant Forrest Calhoun

(b) Address 3035 Pinewood Ave.

17 (a) Burial (b) Date thereof 3/17/48
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery or ~~crematory~~ German Lutheran
Location Reisterstown Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

19 (a) MAR 16 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 14th 1948, at 12 25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 16 1947 to Mar 14 1948 and that I last saw h[illegible] alive on Mar 14 1948

Immediate cause of death [illegible]
Pneumonia & Fever

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. D. Tisdale

Address 314 - W. N[illegible] Date signed 3/18/48

VS 150

D X

1235 Salter

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. C61235

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospital 13-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL, and give town)
(d) Street No. 3137 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) 2137
If yes, name country

2 (a) FULL NAME William J Salter

2 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Separated

6 (b) Name of ~~husband or wife~~ Ina Salter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 3rd 1894

8. AGE: Years 53 | Months 7 | Days 10 11 | If less than one day ..... hr. ..... min.

9. Birthplace Scotland (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER 12. Name Thomas Salter

13. Birthplace England

MOTHER 14. Maiden Name Helen Rogers

15. Birthplace Scotland

16 (a) Informant Mrs. Elizabeth Brewster

(b) Address 2137 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/48 (month) (day) (year)

(c) Cemetery or crematory Balto.

Location " Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

19 MAR 16 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17 1948, at 5:53 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Earl L Ryon M.D. Medical Examiner

Date signed 17 Mar 48

VS 181

1236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92

G61236

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2026 Robb st
(c) Hospital or institution: 4-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2026 Robb st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie G. Berry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband or wife: Wallace L. Berry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 7th 1888

8. AGE: Years 59 | Months 6 | Days 7 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Chas. N. Foster
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Fitch
15. Birthplace Balto. Md.

16 (a) Informant Wallace L. Berry
(b) Address 2026 Robb st.

17 (a) Burial (b) Date thereof 3/18/48
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 MAR 16 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 14th 1948, at 5 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1946, to Mar 14 1948, and that I last saw h alive on 19

Immediate cause of death: Coronary Thrombosis

Due to:

Due to: Valvular Heart disease

Other Conditions: Hypertension Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jacob Fruhan M. D.

Address 18 E. N. Ave. Date signed 3/15/48

X

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 661237

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 134 N. Lanvale
(c) Hospital or institution: at home 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1342 W Lanvale (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country —

3 (a) FULL NAME George Murray Gill Schaefer

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Phyllis P. Schaefer
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 2-1885

8. AGE: Years 62 | Months 7 | Days 13 | If less than one day: hr. min.

9. Birthplace: Georgia (Town, county, and state)

10. Usual Occupation: none

11. Industry or business: none

FATHER
12. Name: Harry Schaefer
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Anita M. Gill
15. Birthplace: Balto. Md.

16 (a) Informant: Mrs. Moses Schaefer (wife)
(b) Address: 134 W Lanvale

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-48 (month) (day) (year)
(c) Cemetery or crematory: Green Mt
Location: Baltimore Md

18 (a) Funeral director: Stewart Morrison
(b) Address: 1018 W Baltimore St.

19 MAR 16 1948 (Date rec'd by registrar) (by) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. - 14 1948, at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1936 to Mar. - 14 1948, and that I last saw him alive on Mar. 12 1948.

	Duration
Immediate cause of death: Coronary Thrombosis	1 hr
Due to: Arteria-Sclerosis	Gradual
Due to: Myocarditis	Y
Due to: Chronic Bronchitis	Y
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: W. H. Neadey M. D.
Address 1403 Park ave. Date signed 3-15-48

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT ✓ 661238 Registered No.

CERTIFICATE OF DEATH 83B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 812-W-35-St-
(c) Hospital or institution: at Home 13-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto City.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 812-W-35-St-
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Frances McCauley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Wm. M. McCauley

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 22-1871

8. AGE: Years 76 | Months 5 | Days 21 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER 12. Name John A. Rice

13. Birthplace Maryland

MOTHER 14. Maiden Name Margaret J. —?—

15. Birthplace Maryland

16 (a) Informant Wm. R. McCauley - son

(b) Address 843-W-37-St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-46 (month) (day) (year)

(c) Cemetery or crematory St Mary's Cemetery

Location Roland Ave.

18 (a) Funeral director Shivaat Mortuary

(b) Address 108 W North Ave.

19. MAR 16 1948 (Date rec'd by registrar) Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 3/14 1948 and that I last saw her alive on 3/13 1948.

Immediate cause of death: cerebral hemorrhage 2nd attack
Due to Arterio Sclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 3 days | yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.

Address 2020 N. Charles Date signed 3/15/48

VS 150

X

239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. 661239

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1709 Barnes St
(c) Hospital or institution: 7-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 Barnes St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Lipscomb Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-0410

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Married

6 (b) Name of husband or wife Laura
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec 25 1909

8. AGE: Years	Months	Days	If less than one day
38	2	20	hr. min.

9. Birthplace Crewe Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethlehem Steel Co

FATHER
12. Name George Lipscomb
13. Birthplace Crewe Va.

MOTHER
14. Maiden Name Eurepia Strutt
15. Birthplace Crewe Va.

16 (a) Informant Laura Lipscomb
(b) Address 1709 Barnes St

17 (a) Removal (b) Date thereof March 7 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Crewe Va.

18 (a) Funeral director Mrs Robt. G. Elliott Dpl
(b) Address 1129 N. Caroline St

19 (a) MAR 16 1948 (b) Huntingtown Methodist Church
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/14/48 1948, at 9:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11/48 19 to 2/14 19 48, and that I last saw him alive on 3/14 19 48.

Immediate cause of death Acute Myocardial Failure — Duration 3 wks

Due to

Due to

Other Conditions Bronchopneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm Garner
Address 514 Division St Date signed 3/14/48

X

240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

661240 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 424 Caulbrick St
(c) Hospital or institution: 25-4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town (If outside city or town limits, write RURAL and give county)
(d) Street No. 424 Caulbrick St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Plummer R. Wade

3 (b) If veteran, name war No
3 (c) Social Security Account No. No
4 Sex Male
5 Color or race White
6 (a) Single, married, widowed, or divorced Widower
6 (b) Name of husband or wife James J. Wade
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 22, 1869
8. AGE: Years 78 Months 5 Days 20 If less than one day, hr. min.
9. Birthplace Anne Arundel Co (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Wade
13. Birthplace Md

MOTHER
14. Maiden Name Dent Brown
15. Birthplace " "

16 (a) Informant Harry Garrett
(b) Address 424 Caulbrick St
17 (a) Burial, cremation, or removal Olivet (b) Date thereof March 17 1948
(c) Cemetery or crematory Loudon Park
Location C.L.C.
18 (a) Funeral director C. Howard Evans
(b) Address 1410 St Charles St
19 (a) [illegible] 6 1948 (b) Registrar Washington Williams M.D.
(State record by [illegible])

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1948, at 0300 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/28/ 1946 to 3/14 1948, and that I last saw him alive on 3/13/ 1948.

Immediate cause of death Cardiac failure due to Arteriosclerotic heart disease — Duration 1 year 4 mos
Due to —
Due to —
Other Conditions None
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Garrett
Address 1206 Hanover St Date signed 3/15/ 1948 M. D.

VS 150-

X

1241

BALTIMORE CITY HEALTH DEPARTMENT ✓ X G61241 Registered No.

CERTIFICATE OF DEATH 170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Elkridge (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Payne Jr.
(b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1908
8. AGE: Years 40 Months Days If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Iron molder
11. Industry or business

FATHER
12. Name Arthur Payne Sr.
13. Birthplace Balto

MOTHER
14. Maiden Name Carrie Gorsuch
15. Birthplace Balto

16 (a) Informant Carrie Payne
(b) Address Elkridge

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem
Location A. A. County
18 (a) Funeral director Joseph Kasmikes Sons
(b) Address 66 W Washington Balto
Hunting Ford Williams, M.D.

MAR 16 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 1948, at 9:20 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema
Due to Fracture of Skull & intra-cranial Hemorrhage
Other Conditions Front. Rt. temporal fracture
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: Homicide ?
(a) Date of injury March 15/48 M.
(b) Where did injury occur? Park Blvd. near Clay's Diner
(c) Did injury occur at home, on farm, industrial place, in public place? Public highway While at work? No.
Means of injury Auto struck Pedestrian

23. Signature [signature] M.D. Medical Examiner.
Date signed 15 Mar 48

X

VS 151

242 SCHOWSKA

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

Registered No. G61242

Cit. 102086

PLACE OF DEATH:
1) Baltimore City, Maryland
2) Street address 4940 Eastern Ave.
3) Hospital or institution: 22-1
Baltimore City Hospitals
4) Length of stay in hospital or inst. (yrs., mos., or days) 1 Year
5) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 808 Williams ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

(a) FULL NAME Frank Nadrowski

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: S

(b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 7 - 1905

8. AGE: Years 42 | Months 6 | Days 7 | If less than one day hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Adam Nadrowski
13. Birthplace Poland

MOTHER
14. Maiden Name Stella Wieczkowski
15. Birthplace Poland

16 (a) Informant James Nadrowski
(b) Address 437-52nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

19 MAR 16 1948 Registered by Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 14 - 1948, at 3.30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-14-1946 to 3-14-1948, and that I last saw him alive on 3-14-1948

Immediate cause of death	Duration
Pulmonary tuberculosis	2 yrs
Due to	
Due to	
Other Conditions laryngeal tuberculosis (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy: None done

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. T. Benford M. D.
Address Balt. City Hosp. Date signed 3-14-48

X

243

BALTIMORE CITY HEALTH DEPARTMENT ✓ G61243 Registered No.

CERTIFICATE OF DEATH 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1011 S. Linwood ave
(c) Hospital or institution: 1-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 S. Linwood ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joanna or Johanna Budzynski
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. widow
6 (b) Name of husband or wife Peter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4 1871

8. AGE: Years (77) 76 | Months 10 | Days 9 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation housework
11. Industry or business

MOTHER / FATHER
12. Name Kessler
13. Birthplace
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Pete Figaseski
(b) Address 1011 S. Linwood ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 / 17 / 48 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus Cem
Location Dundalk Ave

18 (a) Funeral director Stefan J. Fratkowski
(b) Address 1000 S. Linwood Ave

19 (a) 1948 (Date received by registrar) (b) [illegible] (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1948 at 7:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1946 19 , to March 13 1948, and that I last saw h[illegible] alive on March 13 1948.

Immediate cause of death Cerebral Hemorrhage — Duration 3 days
Due to Generalized Arteriosclerosis — Duration Unknown
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. C. Rosenblatt M. D.
Address 3018 O'Donnell St. Date signed 3-15-48

X

1244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 61

Registered No. G61244

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 7-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 36yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2117 McElderry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BESSIE ~~GRODNITZKY~~ GRODNITZKY

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Mar 1948, at 4:43 PM

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Abraham
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1892
8. AGE: Years 56 | Months | Days | If less than one day: hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles
13. Birthplace Russia

MOTHER
14. Maiden Name Hannah
15. Birthplace Russia

16 (a) Informant Abraham Grodnitzky
(b) Address 2117 McElderry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 MAR 16 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

21. I certify that death occurred on the date above stated; that I attended deceased from 3-9 1948 to 3-15 1948, and that I last saw her alive on 3-15 1948.

	Duration
Immediate cause of death: Uremia	
Due to: Chronic glomerulonephritis	
Due to:	
Other Conditions: Hypertension C.V. Lesions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard S Colen M. D.
Address Sinai Hosp, Balto, Md Date signed 3-15-48

VS 150

131B

245 Cert-2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. 661245

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 11-4
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1019 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leonard Walker
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex male
5. Color or race Colored
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9-15-00
8. AGE: Years 47 Months 5 Days 29 If less than one day hr. min.
9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Tim Walker
13. Birthplace Va.
MOTHER 14. Maiden Name ? Lone
15. Birthplace Va
16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-48 (month) (day) (year)
(c) Cemetery or crematory
Location Glasgow, Virginia
18 (a) Funeral director Jesse W. Redden
(b) Address 436 W. Biddle Street
MAR 16 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1948, at 10 J D A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-12 1948 to 3-14 1948, and that I last saw h[illegible] alive on 3-14 1948.

Immediate cause of death GASTRO INTESTINAL HEMORRHAGE — Duration 1 DAY
Due to GENERALIZED LYMPHOSARCOMA WITH THROMBOCYTOPENIA
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide at M
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Florence F. Dyphers M. D.
Address Johns Hopkins Hosp Date signed 3-14-48

VS 130

246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. 163246

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2822 Fox Street
(c) Hospital or institution: 12-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2822 Fox Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Jenkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: MALE

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1869

8. AGE: Years 78 | Months 10 | Days 15 | If less than one day hr. min.

9. Birthplace North CAROLINA (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business

FATHER
12. Name DANIEL Jenkins
13. Birthplace N.C.

MOTHER
14. Maiden Name Unknown
15. Birthplace N.C.

16 (a) Informant MRS. Alice Mills
(b) Address 2822 Fox Street

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-17-48 (month) (day) (year)
(c) Cemetery or crematory MT CALVERY
Location Anne Arundel Co. Md

18 (a) Funeral director MRS. FRANCES A. HENSLEY
(b) Address 5718 W. Biddle St

19 MAR 16 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 13, 1948, at 11:15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from AUGUST 1947 to MARCH 13, 1948 and that I last saw him alive on MARCH 13, 1948.

Immediate cause of death CARDIAC FAILURE — Duration 2 DAYS

Due to Pulmonary Congestion — Duration WEEK

Due to Pneumonia — Duration 2 weeks

Other Conditions Senility — Duration OVER

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard H. Hunt M. D.
Address 1631 W. Franklin St. Date signed 3-15-48

VS 180

61247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 61247

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1713 DESOTA RD
(c) Hospital or institution: 25.7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 Desota Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John KARPER.
3 (b) If veteran, name war No
3 (c) Social Security Account No. 215-03-0007

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife URSULA (WATSON)
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) 9-19-1888

8. AGE: Years	Months	Days	If less than one day
59	6	23	hr. min.

9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation TAILOR
11. Industry or business MENS-TAILORS

FATHER
12. Name Stanley Karper
13. Birthplace Lithuania

MOTHER
14. Maiden Name Marion
15. Birthplace Lithuania

16 (a) Informant URSULA KARPER
(b) Address 1713 DESOTA RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-16-8. (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Charles W. Kaelsnecker
(b) Address 703 McHenry St.

MAR 16 1948 (Date rec'd by registrar) (b) Huntingtown Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1948, at 7:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 Oct 1946 to 12 Mar 1948 and that I last saw h.m alive on 12 Mar 1948.

Immediate cause of death	Duration
Coronary Occlusion	12 Months
Due to Arteriosclerosis	
Cardio-Vascular Disease	1946
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: NO
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward J. Nilson M.D.
Address 608 Gibson Bldg Date signed 15 Mar 48

VS 150

BOLO - 30 MD

X

248 GU. 117228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

Registered No. C61248

1. PLACE OF DEATH: 26-10
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
. Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 17 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 602 N. Highland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fernando Mellado

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-0826

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30- 1891

8. AGE: Years 56 | Months 9 | Days 15 | If less than one day hr. min.

9. Birthplace Chile (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?

13. Birthplace ?

MOTHER 14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-46 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Edmondson Avenue

18 (a) Funeral director Frederick D. Smith & Son

(b) Address 3019 E. Monument St.

19 MAR 16 1948 (Date rec'd by registrar) (b) Huntington Williams Mgr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 14 - 1948, at 4.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2- 27 -1948, to 3 - 14 - 1948, and that I last saw him alive on 3 - 14 - 1948.

Immediate cause of death Heart failure — Duration 12 hr

Due to Rheumatic Heart disease & Mitral stenosis — Duration ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Mitral stenosis

of autopsy: Thrombus left auricle

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William M. Stewart M. D.

Address BCH Date signed 3/15/48

VS 150

249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No. G61249

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 800 S Ellwood Ave

(c) Hospital or institution: 1-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 800 S Ellwood Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Peter J. Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Irene Kelly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 24th 1880

8. AGE: Years 67 | Months 2 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Kelly

13. Birthplace Ireland

MOTHER 14. Maiden Name Catherine Hanley

15. Birthplace Ireland

16 (a) Informant Irene Kelly

(b) Address 800 S Ellwood Ave

17 (a) Burial (b) Date thereof March 18th 1948 (month) (day) (year)
(Burial, cremation, or removal)

(c) Cemetery or crematory Oak Lawn

Location Eastern Ave Road

18 (a) Funeral director John C Moran

(b) Address 3000 Baltimore St

19 (a) MAR 16 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1948, at 11 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1947, to March 14 1948, and that I last saw him alive on March 14 1948.

Immediate cause of death

Chronic Cardiac Failure — Duration

Due to Cardio Vascular Renal

Due to Dyspnea

Other Conditions Carcinoma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. A. Flannigan Jr. M. D.

Address 3503 Fait Ave Date signed 3/15/48

VS-150

131a

1250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C61250
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1301 Park ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Stoneleigh
(If outside city or town limits, write RURAL and give town)
(d) Street No. 662 Regester ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth J. Wilson Heyward

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race white

6 (a) Single, married, widowed, or divorced widowed

6 (b) Name of husband or wife Wilson P Heyward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12 1852

8. AGE: Years 95 Months 8 Days If less than one day hr. min.

9. Birthplace Oakenshaw Balto Co Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry R. Wilson
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Sallie Lloyd Skinner
15. Birthplace Talbot Co Md

16 (a) Informant Miss Mary Heyward
(b) Address 662 Regester ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 16 1948 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry M. Jenkins Sons Co
(b) Address McCulloh & Orchard Sts

MAR 16 1948 (Date received by registrar) (b) Huntington Williams, M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-13-48 19 , at 7:26 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-28-48 19 , to 3-13-48 19 , and that I last saw her alive on 3-13-48 19 .

Immediate cause of death

	Duration
Cerebral thrombosis	2 wks.
Due to Arteriosclerosis	years
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Edward P. Chatard M. D.

Address 1014 St. Paul St. Date signed 3-15-48

251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 83a

Registered No. G61251

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3629 BELVEDERE Ave
(c) Hospital or institution: 27-18

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3629 BELVEDERE Ave (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME GERTRUDE LYTTLE

(b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. WIDOW

6 (b) Name of husband or wife GEO. W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 6, 1875

8. AGE: Years 72 | Months 7 | Days 8 | If less than one day hr. min.

9. Birthplace MD (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business —

FATHER 12. Name MATTHEW O'BRIEN

13. Birthplace UNKNOWN

MOTHER 14. Maiden Name CATHERINE WILMOTT

15. Birthplace UNKNOWN

16 (a) Informant MRS. RUTH SPONSLER

(b) Address 3629 BELVEDERE Ave

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 18, 1948 (month) (day) (year)

(c) Cemetery or crematory LOUDON PARK

Location BALTIMORE, MD.

18 (a) Funeral director Wm. J. TICKNER & SONS

(b) Address BALTIMORE, MD.

MAR 16 1948 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 14 1948, at 6½ P M

21. I certify that death occurred on the date above stated; that I attended deceased from MAR 1 1948 to MAR 14 1948 and that I last saw h/w alive on MAR 14 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	3/1/48
Due to Arteriosclerosis	
Due to	
Other Conditions (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D. Bubert M. D.
Address 4803 Park Heights Av Date signed 3/15/48

VS 159

1252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

✓ 061252 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 W. UNIVERSITY PKY.
(c) Hospital or institution: 12-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) ABOVE ADDRESS 8 YRS
(e) Length of stay in Baltimore (yrs., mos., or days) 65 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 W. UNIVERSITY PKY (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME EMMA P. WARFIELD

(b) If veteran, name war No

3 (c) Social Security Account No. No

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced WIDOWED

(b) Name of husband or wife GUY T. WARFIELD

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) DEC. 6, 1876

8. AGE: Years 71 | Months 3 | Days 8 | If less than one day hr. min.

9. Birthplace ELKRIDGE, MD. (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER

12. Name THOMAS F. PETTIT

13. Birthplace ELKRIDGE, MD.

MOTHER

14. Maiden Name EMMA E. POULTNEY

15. Birthplace BALTIMORE, MD.

16 (a) Informant MR. GUY T WARFIELD JR.

(b) Address MALVEIN AVE; KIRKTON MD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/16/48 (month) (day) (year)

(c) Cemetery or crematory LOUDON PARK

Location BALTIMORE, MD.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address BALTIMORE, MD.

19 MAR 16 1948 (Date rec'd by Registrar) Huntingtown Williams MD (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 March 1948, at 10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1936, to March 14 1948, and that I last saw h er alive on March 12 1948.

Immediate cause of death Myocardial failure — Duration 8 days.

Due to Arterio-sclerosis

Due to —

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at M
(c) Where did injury occur? No (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? None (Specify type of place) While at work? —
(e) Means of injury None

23. Signature D. Calvin Streett

Address 712 Park Ave. Balto. Md. Date signed 14 March M D.

VS 19

97

1253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61 ✓

Registered No. G61253

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: VS-103
WEST BALTIMORE GENERAL HOSPT.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 DAY
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County.....
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2419 ANNAPOLIS ANNE RD
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME MARION JAMES SHILOH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ALICE E.
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) JAN 17, 1901

8. AGE: Years	Months	Days	If less than one day
47	1	26	.....hr. .....min.

9. Birthplace BALTIMORE, MARYLAND
(Town, county, and state)
10. Usual Occupation GAS STATION OPERATOR
11. Industry or business GASOLINE STATION

FATHER
12. Name EMERSON SHILOH
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name MARGARET LEONARD
15. Birthplace BALTIMORE, MD

16 (a) Informant ALICE E. SHILOH
(b) Address 2419 ANNAPOLIS RD

17 (a) BURIAL (b) Date thereof 3-17-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LAUREL PARK CEM.
Location FREDERICK AVE

18 (a) Funeral director Joseph L. Sumbrone, Jr.
(b) Address 414 N. Frankline Rd. Huntington Park Baltimore, Md.

19 MAR 16 1948
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-13- 19 48 at 10.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-13 19 48 to 3-13 19 48 and that I last saw him alive on 3-13 19 48.

Immediate cause of death	Duration
Coronary Occlusion	
Due to Myocardial infarction	
Due to Hypertension arteriosclerotic Cardiovascular disease	
Other Conditions Diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature W. W. Linderman M.D.
Address W. Balto. Gen. H. Date signed 3-14-48

VS 150

939

1254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a ✓

Registered No. 61254

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2321 AIKEN ST.
(c) Hospital or institution: 9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2321 AIKEN ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Guy E. Hartley

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-03-8839

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bessie A.
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) March 28/1887

8. AGE: Years	Months	Days	If less than one day
60 61	11	15	hr. min.

9. Birthplace Balto Co Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Shaffer Turner

FATHER
12. Name Joseph H. Hartley
13. Birthplace Balto. Co Md.

MOTHER
14. Maiden Name Elizabeth Emmart
15. Birthplace Balto. Co. Md.

16 (a) Informant Elizabeth A. Hartley
(b) Address 232 Aiken St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Hayden Av

18 (a) Funeral director John H. Valentine
(b) Address 2326 Aiken St.

MAR 16 1948 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 15 1948, at 1:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to Mar 15 1948, and that I last saw h.i.m. alive on Mar. 14 1948.

Immediate cause of death Coronary thrombosis — Duration 20 hrs.
Due to Arteriosclerosis — 5 yrs.
Due to
Other Conditions Obesity, Mod. — 10 yrs.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robt B. Wright M. D.
Address Maryland Ave Bldg. Date signed 3/16/48

1255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No. G61255

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 203 S. Harmison St.
(c) Hospital or institution: 20-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 203 S. Harmison St.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME August H. Miller

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Mary A. Miller
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1874

8. AGE: Years	Months	Days	If less than one day
73	3	11	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name August Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia ?
15. Birthplace Germany

16 (a) Informant Mrs. Martin C. Prince, Sr.
(b) Address 203 S. Harmison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Maryland

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Avenue

19 MAR 16 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION 15

20. DATE OF DEATH Mar 14, 1948, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1948 to Mar 12 1948, and that I last saw h~~im~~ alive on Mar 12, 1948.

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Generalized Arteriosclerosis Fatty Infiltration	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abram Goldman M.D.
Address 206 E. Belmont Date signed 3/16/48

VS 150

1256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 661256

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 423 Scott St.
(c) Hospital or institution: 21-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 423 Scott St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Margaret F. Burke

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Harry R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15th 1888

8. AGE: Years 59 | Months 8 | Days — | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business at Home

FATHER
12. Name John Smith
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Margaret Geiss
15. Birthplace Baltimore Md

16 (a) Informant Mr Harry R. Burke
(b) Address 423 Scott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director John J. Gowan & Son
(b) Address 901-03 Hollins St.

MAR 16 1948 (Date rec'd by registrar) (Registrar) Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15th 1948, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/13 1948 to 3/15 1948, and that I last saw h[illegible] alive on 3/15 1948.

Immediate cause of death	Duration
Cerbeal Hemorrahage right	2 days
Due to Hypertensive Cardio Vascular Disease	5 yrs.
Due to	
Other Conditions Amputation right leg.	1943

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John P. Ulrich, Jr.
Address 1227 Wash. Blvd. Date signed 3/16/48 M. D.

VS 150 . . .

X

1257 GM. 116260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registration No. 63257

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14-V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Months
(e) Length of stay in Baltimore (yrs., mos., or days) 64 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD, (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1535 Myrtle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Gibson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Missouri Gibson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9 1883

8. AGE: Years	Months	Days	If less than one day
64	6	2	hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Garrison Gibson
13. Birthplace MD.

MOTHER
14. Maiden Name Annie Scarborough
15 Birthplace VA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Wed. B. Kelson
(b) Address 1303 Pressman St

19 MAR 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 11 - 1948, at 7.00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1 - 1 - 1948 to 3 - 11 - 1948, and that I last saw him alive on 3 - 11 - 1948.

Immediate cause of death	Duration
Pulmonary Embolism	
Due to Phlebathrombosis of pelvic or leg veins	
Due to	
Other Conditions Generalized Arteriosclerosis; Benign Prostatic Hypertrophy	

(Include pregnancy within 3 months of death)

Date of operation 3/2/48

Major findings of operation: Biopsy Prostatic Hypertrophy

of autopsy Pulmonary Embolism

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank S. Theasato M.D.
Address Baltimore City Hosp Date signed 3/13/48

1258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

Registered No. 661258

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 16-2
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) D.O.A.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 Moser St. (If rural give location)
(e) Citizen of foreign country? MOSHER (Yes or No)
If yes, name country

3 (a) FULL NAME CARROLL HIGH

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/25/1909

8. AGE:	Years	Months	Days	If less than one day
	38	3	18	hr. min.

9. Birthplace Calvert Co. Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Wesley Hugh
13. Birthplace Calvert Co. Md

MOTHER
14. Maiden Name Sara E. Chase
15. Birthplace Calvert Co. Md

16 (a) Informant Anna Mae
(b) Address 2302 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. G. Kelson
(b) Address 1363 Pressman St

19 (a) MAR 16 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13/1948 at 8:20 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar pneumonia

Due to

Other Conditions Syphilitic aortitis
Fatty degeneration of liver.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 3/15/48

108

VS 191

1259 - 48- 05476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 061259

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: Womans Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) X day
(e) Length of stay in Baltimore (yrs., mos., or days) X day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. (Towson)
(c) City or town [redacted] Providence Rd
(If outside city or town limits, write RURAL and give county)
(d) Street No. — Providence Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Girl Johnson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3/15/48

8. AGE: Years	Months	Days	If less than one day
—	—	—	11 hr. — min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name John Robert Johnson Jr.
13. Birthplace Rescue, Va.

MOTHER
14. Maiden Name Mary Anne Johnson
15. Birthplace Baltimore

16 (a) Informant Father
(b) Address Providence Rd. Towson Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May. 17, 1948 (month) (day) (year)
(c) Cemetery or crematory Chestnut Grove Cem.
Location Jacksonville Balto. Co., Md.

18 (a) Funeral director John Burns' Sons
(b) Address Towson Maryland

19 MAR 16 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16/48 19— at 1A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/15/48 19— to 3/16/48 19—, and that I last saw her alive on 3/16/48 19—

Immediate cause of death PREMATURITY — Duration Min's Life

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M.D.

Address Womans Hospital Date signed 3/16/48

VS 150

1260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Reg. 61260

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1743 Lamont Ave.
(c) Hospital or institution: 8-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 Bethel St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary V. Roche

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Augustus
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1888

8. AGE: Years	Months	Days	If less than one day
59	9	16	14 hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation house wife
11. Industry or business

FATHER
12. Name Albert Aro
13. Birthplace Baltimore

MOTHER
14. Maiden Name Carrie Arnett
15. Birthplace Baltimore

16 (a) Informant Harry J. Smith
(b) Address 1704 Rutland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) MAR 16 1948 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1948, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1, 1947 to March 14 1948
and that I last saw h[illegible] alive on Mar 10 1948.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerosis	
Due to	
Other Conditions Chronic Nephritis, Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel L. Green M. D.
Address 1761 E. North Ave Date signed 3/15/48

VS 150

94a

Neuenschwander

61261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 61261

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University 18-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 810 Hollins Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eddie Neuenschwander

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-2790

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Hanna B

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 25, 1875

8. AGE: Years 72 73 | Months 10 | Days 20 | If less than one day hr. min.

9. Birthplace Lima Ohio (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Retired

MOTHER - FATHER

12. Name Mrs. Neuenschwander

13. Birthplace Berne Indiana

14. Maiden Name Caroline Emeleus

15. Birthplace Lima, Ohio

16 (a) Informant Edwards Funeral Home

(b) Address Troy, Ill.

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof 3/16/48 (month) (day) (year)

(c) Cemetery or crematory Troy

Location Troy Ill

18 (a) Funeral director Edwards

(b) Address Troy Ill

19 (a) MAR 16 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/13/48 19 , at 7:37 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R Davis M.D. Medical Examiner.

Date signed 3/14/48

61262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G61262

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4011 Edmondson Ave.
(c) Hospital or institution: 20-07
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4011 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret R. Elder

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W.	Widow

6 (b) Name of husband or wife Late William P. Eld
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1861.

8. AGE: Years	Months	Days	If less than one day
86	11	27	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name August Rehling
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa ----------
15. Birthplace Germany

16 (a) Informant Mr. Arthur Elder
(b) Address 4011 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 17/48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave. & Longwood St

18 (a) Funeral director Harry A. Little
(b) Address 4101 Edmondson Ave.

19 MAR 16 1948 (Date rec'd by registrar) (b) Huntington [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14/48. 19 , at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 14 1948. to March 14 1948.
And that I last saw h E R alive on March 14 1948.

	Duration
Immediate cause of death Cardio - Resp. Failure.	2hrs 20 min.
Due to cerebral - Vascular accident	2hrs 20 min.
Due to Arterio - sclerosis	?
Other Conditions Chronic Glaucoma Bilateral Cataracts (Include pregnancy within 3 months of death)	8yrs.

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul R. Zeigler
Address 3723 Edmondson Ave Date signed 3/14/48 M. D.
for Dr. H. E. Kammer Jr., M. D.
Howard J. Malecki, M. D. X

VS 150

1263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44 B

Registered No. 61263

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5100 Edgar Terrace
(c) Hospital or institution: 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5100 Edgar Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob G. Gettman

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-03-9549

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Margaret R. Buchmaster

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/7/1886

8. AGE: Years 61 | Months 10 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business Manufg. Hoods

FATHER 12. Name Jacob Gettman

FATHER 13. Birthplace Baltimore

MOTHER 14. Maiden Name Margaret Regue

MOTHER 15 Birthplace Baltimore

16 (a) Informant Mrs J. G. Gettman

(b) Address 5100 Edgar Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/48 (month) (day) (year)

(c) Cemetery or crematory Moreland

Location Taylor ave.

18 (a) Funeral director J. J. Zoher Sons

(b) Address 218 Lexington St

19 (a) MAR 16 1948 (Date received by registrar)

(b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1948 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 14 1947 to Mar. 16 1948 and that I last saw h[illegible] alive on March 15 1948

Immediate cause of death Hodgkins Disease — Duration 1 Yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carl F. Benson M.D.
Address 511 York Rd Date signed 3/16/48

Carl F. Benson X

61264

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH / 97

Registered No. C61264

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1626 St. Paul Street
(c) Hospital or institution: 17-05
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 St. Paul Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM FREDERICK KUHN

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. 220-07-5211

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Emma K.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1864

8. AGE: Years 84 | Months 1 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Cigar Maker
11. Industry or business

FATHER
12. Name Louis Kuhn
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Dettmer
15. Birthplace Germany

16 (a) Informant Miss Stella Kuhn
(b) Address 1626 St. Paul Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) MAR 16 1948 (Date received by registrar) (b) [illegible] Washington Boulevard

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1948, at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1948 to March 15 1948 and that I last saw h[illegible] alive on March 14 1948.

Immediate cause of death	Duration
Myocardial failure	6 weeks
Due to Arteria-sclerosis (Cerebral)	1 yrs
Due to General arteria-sclerosis	3 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I Frederick Lantz
Address Temple Garden Apt Date signed 3/15-48

VS 150

X

BC-48-6541/2
61265

GM. 118019

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

Registered No. G61265

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern 7-4
(c) Hospital or institution:
Baltimore City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) N.B.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1026 N. Washington ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jeffers Baby Boy (Jessie

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 8 -1948

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace MD.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Robert Jeffers
13. Birthplace N.C.
14. Maiden Name Jessie Paylor
15. Birthplace N.C.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremated (b) Date thereof 9am 3-12-1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) MAR 16 1948 (b) Huntington Williams, M.D.
(Must not be day of death) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 10 - 1948, at 1.45A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3 - 8 - 1948, to 3 - 10 - 1948, and that I last saw him alive on 3 - 10 - 1948.

Immediate cause of death	Duration
Prematurity Wt = 2 1/2 lbs.	2 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Prematurity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julian P. Griffin M. D.
Address Balt City Hosps. Date signed 12 Mar '48

VS 150

1266 48-04669 B-117785

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

Registered No. G61266

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 13-3
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2503 Woodbrook Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy-Franklin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27- 1948

8. AGE: Years	Months	Days	If less than one day
		11	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Harold Franklin
13. Birthplace Md.

MOTHER
14. Maiden Name Beatrice Augers
15. Birthplace N.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 9am 3-12-1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) MAR 16 1948 (Date rec'd by registrar) Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8- 1948, at 3-30PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-27- 1948, to 3-8- 1948, and that I last saw him alive on 3-8- 1948.

Immediate cause of death	Duration
Pneumonia	2 days
Due to	
Due to	
Other Conditions Prematurity	10 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Inflamed colon - premature

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide at M
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julian P. Thoffer M. D.
Address Balt. City Hosps. Date signed Mar 12 48

119a

1948-7966
48-05403

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 661267

160a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 19-1
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl-Pinder-Twin B

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7-1948

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Pinder
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Mason
15. Birthplace Baltimore, Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 9am 3-12-1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) MAR 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9- 1948, at 8.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-7- 1948, to 3-9- 1948, and that I last saw her alive on 3-9- 1948.

Immediate cause of death	Duration
Prematurity	1 day
Due to	
Due to	
Other Conditions Atelectasis	1 day

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Prematurity and Subarachnoid Hemorrhage

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julien P. Griffin M. D.
Address Balt City Hosps. Date signed Mar 12 '48

159

1268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 117a

Registered No. 661268

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE AND JOHN
(c) Hospital or institution: WOMAN'S HOSPITAL 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 71 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1416 LINDEN
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME EFFIE BACHMAN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 8, 1875

8. AGE: Years 72 | Months 4 | Days 8 | If less than one day ..... hr. ..... min.

9. Birthplace BALTIMORE — MARYLAND
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name JOHN BACHMAN
13. Birthplace BALTO

MOTHER
14. Maiden Name AGNES WRIGHT
15. Birthplace BALTO

16 (a) Informant MRS RHODA GRIFFIN
(b) Address 1416 LINDEN

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/19/48 (month) (day) (year)
(c) Cemetery or crematory OAKLAWN
Location BALTO. MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTIMORE MD

19 (a) MAR 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 Mar 1948, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 23 Feb 1948 to 16 Mar 1948, and that I last saw h[illegible] alive on, 16 Mar 1948.

	Duration
Immediate cause of death: Cardiac resp. failure	
Due to: Arteriosclerosis	?
Due to: Perforated peptic ulcer	?
Other Conditions: Chronic myocardial disease 12 yrs Hypertensive arteriosclerosis	

Date of operation
Major findings of operation:
of autopsy [illegible] 2 old infarctions

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph B Greene Jr. M. D.
Address Woman's Hosp Date signed 3-16-48

VS 150

X

61269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 61269

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 726 HARFORD AVE
(c) Hospital or institution: 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 726 HARFORD AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME JOHN F. DELANEY

3 (b) If veteran, name war —

3 (c) Social Security Account No. 705-10-7384

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUL. 14, 1882

8. AGE: Years 65 | Months 8 | Days 1 | If less than one day hr. min.

9. Birthplace BALTO., MD. (Town, county, and state)

10. Usual Occupation —

11. Industry or business W. MD. R.R.

FATHER 12. Name JOHN F. DELANEY

13. Birthplace IRELAND

MOTHER 14. Maiden Name JULIAN GOLDEN

15 Birthplace BALTO., MD.

16 (a) Informant MRS REBA M. GORMAN

(b) Address 726 HARFORD AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/17/48 (month) (day) (year)

(c) Cemetery or crematory NEW CATHEDRAL

Location BALTO., MD.

18 (a) Funeral director WM. J. TIGNER & SONS

(b) Address BALTO. MD.

19 (MAR 16 1948) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/15/48, at 2:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6 1941, to Mch 14 1948, and that I last saw h[im] alive on Mch 14 1948.

Immediate cause of death: Chronic suppurative bronchitis and suppurative degeneration — Duration: 7 years

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.

Address 1250 EUTAW PL Date signed Mch 16 1948

VS 150

61270 McNEAL

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 61270

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 306-S. Collins Ave.
(c) Hospital or institution: 20-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 306-S. Collins Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry C. McNeal.

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Christina Mc. Neal.

6 (c) If alive, give age 85 years

7. Birth date of deceased (mo., day, yr.) January-31-1859.

8. AGE: Years 89 | Months 1 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland.
(town, county, and state)

10. Usual Occupation Retired Machinack.

11. Industry or business Balto. Transit Co.

FATHER
12. Name Joseph Mc. Neal.
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Md.

16 (a) Informant Mrs. Agnes Lancaster.
(b) Address 306-S. Collins, Ave.

17 (a) Burial. (b) Date thereof 3/17/1948.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore-Md.

18 (a) Funeral director Charles J. Schwab
(b) Address 3512-Frederick Ave.

19 (a) MAR 16 1948 (b) [illegible]
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/15/48 19 6.45p M

21. I certify that I took charge of the remains described above, held an INSP. & INQUIRY thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John Rhoads, M.D.
Medical Examiner.
Date signed 3/16/48

VS 151

1271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 128

Registered No. 61271

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 16-2
(b) Street address 1500 Blk Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1226 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie M. Harris Belt.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Robsby Belt.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): September 20, 1904

8. AGE: Years 43 | Months 5 | Days 23 | If less than one day hr. min.

9. Birthplace: Seal, Russell Co., Ala.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: March Holmes.
13. Birthplace: Seal, Russell Co. Ala.

MOTHER
14. Maiden Name: Ella Shaddrick
15. Birthplace: Seal, Russell Co. Ala.

16 (a) Informant: Robsby Belt.
(b) Address: 1226 N. Stricker St.

17 (a) [illegible] (b) Date thereof: March 17 1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location: Columbus Georgia

18 (a) Funeral director: Mrs Katie R. Williams
(b) Address: 322 N. Schroeder St.

19 (a) MAR 16 1948 Tarrington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/13/48, at 10:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5 1948 to 3/13 1948 and that I last saw h[illegible] alive on 3/13 1948

Immediate cause of death	Duration
(a) Cerebral Embolism	3/5/48
(b) Secondary Shock	3/13/48
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation: 3/10/48
Major findings of operation: Embolus in Left Auricle
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? What at work?
(Specify type of place)
(e) Means of injury

23. Signature: H. A. Kelsome M. D.
Address: 113 W. Fallen Ave. Date signed: 3/13/48

VS-150

G61272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G61272 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4801 Fleet St.,
(c) Hospital or institution: 26-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4801 Fleet St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
EDWARD BEVERLY SWIFT

3 (b) If veteran, name war: Spanish-American
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Carolyn Swift
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1879

8. AGE: Years	Months	Days	If less than one day
68	2	29	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Adjuster- etired
11. Industry or business Baltimore Transit Co.,

FATHER
12. Name William Swift
13. Birthplace Scotland

MOTHER
14. Maiden Name Rebecca Leonard
15. Birthplace Maryland

16 (a) Informant Mrs. Carolyn Swift
(b) Address 4801 Fleet St.,24

17 (a) Burial (b) Date thereof May 17-th
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto Nat Cem
Location Rural
18 (a) Funeral director Uelrich Funeral Home
(b) Address 2008 Orleans St
19 (a) MAR 16 1948 (b) Washington, D. C.
(Date rec'd by registrar)

V3 153

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 1947 (19)48, at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6th 1948 to 3/13th 1948
and that I last saw h[illegible] alive on 3/13th 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	8 days
Due to Hypertension	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. J. Lankton M. D.
Address 1002 Eutaw [illegible] Date signed 3/16/48

X

G61273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

109B

G61273 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2902 O'Donnell St.
(c) Hospital or institution: 1-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2902 O'Donnell St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

1. (a) FULL NAME CHARLES HOFFMAN (Fredk C)
(b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married
(b) Name of husband or wife Pauline Hoffman
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 66 | Months | Days | If less than one day ....hr. ....min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation General Laborer
11. Industry or business

MOTHER / FATHER
12. Name Charles Hoffman Sr
13. Birthplace Germany
14. Maiden Name Dora Meyer
15. Birthplace Germany

16 (a) Informant Mrs Wm Peterman Jr
(b) Address 137 S Calvert St

17 (a) Burial (b) Date thereof March 17 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Carmel Cem
Location City

18 (a) Funeral director Wells & Funeral Home
(b) Address 2008 Orleans St

19 (a) MAR 16 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1948, at 10. P.M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner
Date signed 3-15-48

VS 181

61274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161B

Registered No. 061274

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 255
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1331 Eutaw St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred W. McClaskey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-7-48

8. AGE: Years	Months	Days	If less than one day
—	—	13	— hr. — min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alfred W. McCLASKEY
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Dorothy Mitchell
15. Birthplace Balto Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 3-17-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A A Co

18 (a) Funeral director Bernard C. Hasle
(b) Address 121 E. West St.

19 MAR 16 1948 (Signature of Registrar) Hunterton Williams M.D. Registrar

Certificate approved by M.E

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-15-48 at 6:56 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15 1948 to 3-15 1948, and that I last saw h alive on 19

Immediate cause of death Duodenal ulcer

Due to Septicemia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Perforated ulcer

of autopsy: Ulcer perforated

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. J. R. Davis by Howard T. Meeks, M.D.
Address Date signed 3/16/48 M. D.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 661275

GM. 117915

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1912 Bolton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME James Watson-or-James Watts

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

(b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. ?-1876

8. AGE: Years	Months	Days	If less than one day
72	1		hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3/19/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location [redacted] Mar 15 1948

18 (a) Funeral director [redacted] J. J. Raney & Sons
(b) Address 1318 Light St.

19 MAR 16 1948 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

AM

20. DATE OF DEATH March 5 1948, at 11.23 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4 1948 to 3-5 1948, and that I last saw h. im alive on 3-5-48 19

Immediate cause of death

Pulmonary Edema [redacted] — Duration 1 day

Due to Arteriosclerotic Heart Disease — yrs

Due to

Other Conditions Bronchopneumonia both

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. E. Robinson Jr. M. D.

Address Balt. City Hosp. Date signed 3/19/48

VS 150

X

1276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48-05042 / 159

G61276
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address South Balt Gen. Hosp
(c) Hospital or institution: 1213 Light St., Balt. 30 Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1/2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 1/2 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Balt. City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8201, Northern Rd, 22 (If rural give location)
(e) Citizen of foreign country? NO, (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Roberts

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/5/48

8. AGE: Years	Months	Days	17 If less than one day
—	—	1	41 hr. 26 min.

9. Birthplace South Balt. Gen. Hosp. (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Harry Kenneth Roberts
13. Birthplace Charlottesville, Va

MOTHER
14. Maiden Name Patricia Dolores Hyde
15. Birthplace Schenectady, N. Y.

16 (a) Informant Father
(b) Address 8201 Northern Rd, Balt. 22

17 (a) City Disposal (b) Date thereof (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Johns Hopkins Medical School MAR 15 1948
Location Commissioner of Health

18 (a) Funeral director
(b) Address

MAR 16 1948 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/7/48 1948, at 3:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5 1948 to 3/7 1948 and that I last saw h-er alive on 3/7 1948

Immediate cause of death	Duration
Cardiac & Resp. failure	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Kellow M.D.
Address South Balto Hosp Date signed 3/11/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G61277

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LATROBE HTS - 2 E. READ ST.
(c) Hospital or institution: 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 E. READ ST. (LATROBE HTS.)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** CHARLES RADLEY WEBBER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT 19, 1873

8. AGE: Years	Months	Days	If less than one day
74	5	26	hr. min.

9. Birthplace STAFFORD, N.Y.
(Town, county, and state)

10. Usual Occupation GENRL ATTY.

11. Industry or business B. O. RR.

FATHER
12. Name JOHN H. WEBBER
13. Birthplace N.Y.

MOTHER
14. Maiden Name MARY JANE RADLEY
15 Birthplace N.Y.

16 (a) Informant MR. CORNWALL
(b) Address STAFFORD, N.Y.

17 (a) ~~Burial~~ Removal (b) Date thereof (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or ~~crematory~~ STAFFORD CEM.
Location STAFFORD, N.Y.

18 (a) Funeral director Wm J. TICKNER & SON
(b) Address BALTIMORE, MD.

19 MAR 16 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/15 1948, at 4a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1947, to 3/15 1948, and that I last saw ~~him~~ alive on 3/13 1948.

Immediate cause of death	Duration
coronary Thrombosis	1 day
Due to Generalized sclerosis	5 years.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hilbert T. Rheinuss M. D.
Address 6 E Biddle St Date signed 3/16/48

VS 159

G61278

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G61278

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution Maryland University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore - Parkton
(If outside city or town limits, write RURAL and give town)
(d) Street No. Lombard & Greene
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida V. Wilhelm

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife Geo W Wilhelm
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 14 1869

8. AGE: Years 78 | Months 9 | Days 2 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Hsekpr

11. Industry or business

FATHER 12. Name Zachariah Hall
13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth Hare
15. Birthplace Md

16 (a) Informant Raymond Wilhelm
(b) Address Parkton Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 19/48 (month) (day) (year)
(c) Cemetery or crematory Forestview
Location Baltimore Md

18 (a) Funeral director Edw C Tipton
(b) Address Hampstead Md

19 MAR 16 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16 1948, at 3 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/14 1948 to 3/16 1948, and that I last saw h[illegible] alive on 3/16 1948.

Immediate cause of death	Duration
CVA	2 days
Due to Art sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. B. Newburn, M.D.
Address Ave Hope Date signed 3/16/48 M.D.

VS 150

1279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160 C

G61279

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Essex 21, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 B. Dartford, Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Ker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife [illegible]

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-15-1948

8. AGE: Years | Months | Days 1 | If less than one day ____ hr. ____ min.
N.B.

9. Birthplace Sinai Hosp. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Dr. William O. Ker
13. Birthplace Carlisle, Pa

MOTHER
14. Maiden Name Mabel A. Sarsfield
15. Birthplace Philadelphia, Pa

16 (a) Informant Dr. William O. Ker
(b) Address 1623 B. Dartford, Rd.

17 (a) ____ (Burial, ~~cremation~~, or removal) (b) Date thereof 3 17 1948 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Belair Road.

18 (a) Funeral director Schumann Funeral Home
(b) Address 2601-3-5 Madison Ave.

19 (a) MAR 17 1948 (Date rec'd by Registrar) (b) Name of undertaker for Wm. [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16 1948, at 9:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15 1948, to 3-16 1948, and that I last saw h[illegible] alive on 3-16-1948.

Immediate cause of death: Respiratory failure — Duration
Due to: Prematurity
Due to:
Other Conditions: Cesarian section for central Diaphragmatic hernia (Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Was autopsy: ~~requested~~ undetermined as yet

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert W. Jarkins M. D.
Address Sinai Hosp. Date signed 3-16-48

VS 150

159

1280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 661380

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 835 N. Lakewood Ave.
(c) Hospital or institution: 1-V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 835 N. Lakewood Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

(a) FULL NAME [redacted] Rosine J. Steiver

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife George A. Steiver

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1880

8. AGE: Years 67 | Months 6 | Days 2 | If less than one day hr. min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jacob Ziegler
13. Birthplace Germany

MOTHER
14. Maiden Name Pauline Keller
15. Birthplace Germany

16 (a) Informant George A. Steiver - husband
(b) Address 835 N. Lakewood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/48 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Moreland Mem. Park
Location 5806 Harford Rd. Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc
(b) Address 2601-3-5 E. Madison Street

19 MAR 17 1948 (Date rec'd by registrar) [redacted] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 March 1948, at 8:55 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [redacted] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congestive Heart Failure

Due to Arterio-sclerotic C.V. Renal Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [redacted] M.D.
Medical Examiner.
Date signed 17 March 48

VS 151

1281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C61281

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3617 Elm Ave.
(c) Hospital or institution: 13-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3617 Elm Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles B. Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-4399

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth B. Mitchell
(c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) July 2, 1867

8. AGE: Years 80 | Months 8 | Days 11 | If less than one day ... hr. ... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Blacksmith Retired

11. Industry or business Bartlett Hayward & Co.

FATHER
12. Name Edward Mitchell
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Carr.
15. Birthplace Md.

16 (a) Informant Elizabeth B. Mitchell
(b) Address 3617 Elm Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 16 1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Paul E. Schenouth Jr.
(b) Address 3617-19 Edmondson Ave.

19 MAR 17 1948 (Registrar's signature) Washington Metropolitan (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1947 to 3/13 1948, and that I last saw h alive on 3/12 1948.

Immediate cause of death: Coronary Thrombosis,

Due to: Senile Pneumonia

Due to: Advanced Arterio Sclerosis

Other Conditions:
(Include pregnancy within 3 months of death)

Duration: — / — / — / — / 4 yrs.

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. W. Wolff M.D.

Address 2020 N. Charles Date signed 3/13/48

VS 150

282

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G61282

1316

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland
(c) Hospital or institution:
Sinai Hosp 27-17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3305 W Rogers Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth ROSEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced,
Female	White	Married

6 (b) Name of husband or wife David I,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec, 25, 1918

8. AGE: Years	Months	Days	If less than one day
29	2	20	22 hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business House Wife

FATHER
12. Name William Joseph Quirmbach
13. Birthplace Germany

MOTHER
14. Maiden Name Rosa Bauman
15. Birthplace Germany

16 (a) Informant David I Rosen
(b) Address 3305 W Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 18, 1948 (month) (day) (year)
(c) Cemetery or crematory Arlington Cemetery
Location Rogers Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 MAR 17 1948 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1948 at 3:30 PM

21. I certify that death occurred on the date above stated: that I attended deceased from March 8 1948 to March 16 1948, and that I last saw her alive on March 16 1948.

Immediate cause of death	Duration
Uremia	
Due to Chronic Nephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Edward Yaehlen M. D.
Address Sinai Hosp. Date signed March 16

VS 180

1283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43a

Registered No. 61283

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Levindale Home
(b) Street address Belvedere Ave & Greenspring
(c) Hospital or institution: 15-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1736 W North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Ida E. Kimmel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 66 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business House Wife

FATHER
12. Name Aaron Shuham
13. Birthplace Russia

MOTHER
14. Maiden Name Dora Getz
15. Birthplace Russia

16 (a) Informant Louis Kimmel
(b) Address 1736 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 17, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Washington Rd Cem
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 MAR 17 1948 (Date rec'd by registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 16 1948, at 6 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to MAR. 16 1948, and that I last saw h[illegible] alive on MAR. 16 1948.

	Duration
Immediate cause of death: Cerebral hemorrhage	
Due to: Hypertension	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Jerome J. Weinberg, M.D.
Address Levindale Hebrew Home Date signed 3/16/48

VS 150

X

284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓83a

Registered No. 661284

1. PLACE OF DEATH: Levindale Home
(a) Baltimore City, Maryland
(b) Street address Belvedere Ave & Greenspring Ave
(c) Hospital or institution:
3-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2423 Callow Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Meyer Burka

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Late Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 70 69 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business City Of Baltimore

FATHER
12. Name Abraham Burka
13. Birthplace Russia

MOTHER
14. Maiden Name Rachel ?
15. Birthplace Russia

16 (a) Informant Mrs Esther Eisenberg
(b) Address 2423 Callow Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 194[illegible] (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run Cem.
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

MAR 17 1948 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1948, at 11:37 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1948 to March 16 1948, and that I last saw h[illegible] alive on March 16 1948.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Hypertension	
Due to	
Other Conditions Pulmonary edema	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome J. Blumberg M. D.
Address Levindale Hebrew Home Date signed 3/16/48

VS 150

285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8313

Registered No. C61285

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monumental Rutland
(c) Hospital or institution:
Sinai Hosp 27-18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ mo
(e) Length of stay in Baltimore (yrs., mos., or days) Life ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3327 W Garrison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Samuel ~~Smid~~ Weiner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 73 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

MOTHER / FATHER

12. Name Not Known

13. Birthplace Russia

14. Maiden Name Not Known

15. Birthplace Russia

16 (a) Informant Fannie Weiner

(b) Address 3327 W Garrison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-48 (month) (day) (year)

(c) Cemetery or crematory
Location Hebrew Herring Run

18 (a) Funeral director Jack Lewis Inc

(b) Address 2106 Eutaw Place

19 MAR 17 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16 1948, at 3 95 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1948 to 3/16 1948 and that I last saw h. J. alive on 3/15 1948

	Duration
Immediate cause of death: Cerebral embolus	2 Days
Due to: Pul. Embolus	2 mos.
Due to: Card. insuff.	3 mos
Other Conditions: Pul. Consolidation	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Emboli - multiple

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Rosenberg M.D.
Address Sinai Hosp Date signed 3/16/48

VS 189

X

286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 661286

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1127 E. Lombard St
(c) Hospital or institution 3-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 37yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 E. Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Jacob Hymer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 59 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Grocers

11. Industry or business

FATHER 12. Name Harris
13. Birthplace Poland

MOTHER 14. Maiden Name Yenta
15. Birthplace Poland

16 (a) Informant Fannie Hymer
(b) Address 1127 E Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-17-48 (month) (day) (year)
(c) Cemetery or crematory B'Nai Israel
Location Southern Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 710 a Eutaw Place

7 19 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 - 1948 at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1947, to March 16 1948, and that I last saw h alive on Feb. 12 1948.

Immediate cause of death Coronary Thrombosis — Duration 1 hour

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Lyons
Address 3101 W Fredrick St Date signed 7/17/48

VS 150

287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C6T287

PLACE OF DEATH:
1. Baltimore City, Maryland
2. Street address 1219 Widmer Court
3. Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1219 Widmer Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

(a) FULL NAME Emma Scott

(b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, ~~married, widowed, or divorced~~: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/2/1907

8. AGE: Years 40 | Months 0 mos | Days 2 | If less than one day: hr. 1907 min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Laundress

11. Industry or business

FATHER 12. Name Samuel Scott
13. Birthplace Va

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Florence Hunt
(b) Address 1219 Widmer Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-48 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Mt. Calvary

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna Ave

MAR 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-15 1948, at 6:50 P.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Syphilitic Aortitis
Aortic Incompetency

Due to

Other Conditions Hypertrophy & Dilatation of Heart

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mendes M.D. (Medical Examiner)
Date signed 3-16-48

288 JL - 118065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G61288 Registered No. 131a

PLACE OF DEATH:

1. (a) Baltimore City, Maryland
   (b) Street address 4940 Eastern Ave. 21-1
   (c) Hospital or institution: Baltimore City Hospitals
   (d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
   (e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 Briscoe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME John Riley

(b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gertrude
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1889

8. AGE: Years 58 | Months 11 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Ky (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George Riley
13. Birthplace Ky

MOTHER 14. Maiden Name Kathryn Taylor
15. Birthplace Ky

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem.
Location Balto City

18 (a) Funeral director Isaac L. Brunt Son
(b) Address 08 W Monument St

19 MAR 17 1948 (Date rec'd by Local Reg.) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1948, at 9 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1948, to March 14 1948, and that I last saw him alive on March 14 1948.

	Duration
Immediate cause of death: Uremia	1 week?
Due to: Arteriolar nephrosclerosis.	?
Due to: Cardiac insufficiency	7 months
Due to: Hypertrophy of Arteriosclerotic Cardiovascular Disease	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp Date signed 3-15-48

VS 139

X

61289

HEALTH DEPARTMENT—CITY OF BALTIMORE

61289

CERTIFICATE OF DEATH

131a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1122 Etting St., 17-V Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME George Myers

If U. S. Veteran specify WAR

(a) Residence: No. 1122 Etting St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. Color or Race: Colored

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of: Florence

6. DATE OF BIRTH (month, day, year): April 10 1873

7. AGE: Years 74; Months 11; Days 3; If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Hostler

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country): Wash. D.C. U.S.A.

FATHER

13. NAME: Unknown

14. BIRTHPLACE (city or town) (State or country): Unknown

MOTHER

15. MAIDEN NAME: Unknown

16. BIRTHPLACE (city or town) (State or country): Unknown

17. INFORMANT: Mrs. Florence E. Myers

(Address) 1122 Etting St.

18. BURIAL, CREMATION, OR REMOVAL: Centerville, Md. Date 3/17/ 19 48

19. UNDERTAKER: Jas. H. Gallion

(Address) 631 Druid Hill Ave.

20. FILED MAR 17 1948 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): March 13 1948

22. I HEREBY CERTIFY, That I attended deceased from Feb. 28 1948 to Mch 12 1948

I last saw him alive on Mch 12 1948 Death is said to have occurred on the date stated above, at 9A m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cardio-Vascular Renal Disease	9 1
Other contributory causes of importance: Senility	

Was an operation performed? No Date of —

For what disease or injury? —

Name of operation —

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) E. B. Hughes M. D.

(Address) 413 Druid Hill Ave

X

1290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G61290 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17-1
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 537 Moore Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER THOMAS

(b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Bessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 10, 1886

8. AGE: Years 62 | Months 63 | Days 1 | If less than one day hr. min. 3

9. Birthplace Anne Arundel Co. Md. (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER 12. Name Thomas S Lyman

13. Birthplace Anne Arundel Co. Md

MOTHER 14. Maiden Name Mary Anderson

15. Birthplace Anne Arundel Co. Md

16 Eugene + Gladys Coley

(b) Address 920 Stoddard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion

Location Baltimore Md

18 (a) Funeral director Wm. Geo. A. Stollard

(b) Address 1631 Druid Hill Ave

19 (a) MAR 17 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/18/48 19 , at 8:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R Davis M.D. Medical Examiner.

Date signed 3/14/48

VS 181

291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G61291

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 19-3
(b) Street address 110 N. Calhoun
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 414 S. Carrollton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME McCarron, Augusta (Augusta McCarron)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	W	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 17 1876

8. AGE: Years	Months	Days	If less than one day
71	4	4	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Augustus Dodge

13. Birthplace —

14. Maiden Name Margaret Murray

15. Birthplace —

16 (a) Informant Alice B. Kemp
(b) Address 414 S. Carrollton Ave

17 (a) Burial (b) Date thereof March 18 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Balto Co Md

18 (a) Funeral director Pratt & B. M. Walker
(b) Address Pratt & Stricker Sts

MAR 17 1948
(Date rec'd by registrar) Hunter Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16 1948, at 5 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 5 1948, to Mar 16 1948, and that I last saw h[illegible] alive on Mar 16 1948

Immediate cause of death	Duration
Uremia	
Due to Nephrosclerosis.	
Due to	
Other Conditions Cerebral hemorrhage	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Small granular kidneys

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. J. Loham M. D.

Address Franklin Sq Hosp Date signed 3-16-48

COPIES ARE NOT ACCEPTABLE

292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97 ✓

Registration No. 64292

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1825 N. Milton Ave
(c) Hospital or institution: 8.2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1825 N. Milton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha S. Stecker

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Widowed

6 (b) Name of husband or wife Louis Stecker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4 - 1865

8. AGE Years	Months	Days	If less than one day
82	10	11	hr. min.

9. Birthplace Germany
(Town, county and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name — Rauschenbach
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Geo. Schwartz
(b) Address 1825 N. Milton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 18 48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location "

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St

MAR 17 1948 (Date rec'd by registrar)
(b) [illegible] Washington Boulevard

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 15 1948, at 9:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from MAR 5 1948 to MAR 15 1948, and that I last saw him alive on MAR. 13 1948.

Immediate cause of death	Duration
SENILITY	5 YRS +
Due to	
Due to	
Other Conditions GENERAL ARTERIOSCLEROSIS "	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John W. Machen M. D.
Address 631 Belair Rd. Date signed 3/16/48

V S 150

162 B

1293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a

Registered No. G61293

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga Sts.

(c) Hospital or institution: Mercy Hospital 8.V

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days

(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore #13 (If outside city or town limits, write RURAL and give town)

(d) Street No. 1634 N. Montford Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Edith E. Ford

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F.

5. Color or race Wh.

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1878

8. AGE: Years 69 | Months 6 | Days 28 | If less than one day ..... hr. ..... min.

9. Birthplace Eastern Shore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Alexander James

13. Birthplace Md.

MOTHER

14. Maiden Name Nina Gibson

15. Birthplace Md.

16 (a) Informant Etta Herbert

(b) Address 1634 Montford Ave. Balto.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Mar 19/48 (month) (day) (year)

(c) Cemetery or crematory Tilghmans Island M.E. Cem.

Location Tilghman's Island Md.

18 (a) Funeral director Philip Henry Lord

(b) Address 2024 Eutaw St

19 MAR 17 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16 1948, at 5 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-25 1948, to 3-16 1948, and that I last saw her alive on 3-16 1948.

Immediate cause of death	Duration
Carcinomatosis	4 to 8 years
Due to	
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 3-5-48

Major findings of operation: Carcinomatosis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Robert Johnson M. D.

Address Mercy Hospital Date signed 3-16-48

VS 150

X

294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G61294
Registered No.

1. PLACE OF DEATH: 6-4
(a) Baltimore City, Maryland
(b) Street address 23 W Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 39 days
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 432 N. Washington St. Balto 31
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Mr John Rosskopf (JOHN J. ROSSKOPF)
(b) If veteran, name war
(c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mrs. Helen Rosskopf
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11, 1890

8. AGE: Years 58 | Months 0 | Days 5 | If less than one day ..... hr. ..... min.

9. Birthplace Bavaria (Town, county, and state)

10. Usual Occupation Baker

11. Industry or business

FATHER
12. Name Sebastian Rosskopf
13. Birthplace Bavaria

MOTHER
14. Maiden Name Frances Myer
15. Birthplace Bavaria

16 (a) Informant Mrs Helen Rosskopf
(b) Address 432 N. Washington St. Balto

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 7 Mar 1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Eutaw St

19 (a) 3/9/48 (Date received by Registrar) (b) Washington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1948, at 11:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6 1948, to 3/16 1948, and that I last saw him alive on 3/16 1948

Immediate cause of death: Carcinoma of Liver - primary — Duration: 3 months
Due to:
Due to:
Other Conditions: Hypertension, Heart disease - Hydrocele, left — 6 months
(Include pregnancy within 3 months of death)

Date of operation 3/5/48

Major findings of operation: Primary carcinoma of liver

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter L Mollins M. D.
Address Union Memorial Hosp Date signed 3/16/48

vs 150

1295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

Registered No. 661295

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12-1
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3913 Juniper Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

2 (a) FULL NAME Mr. Harvey Wilson

(b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	M

6 (b) Name of husband or wife Lillian D. Von Munchow

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec 17 1881

8. AGE: Years	Months	Days	If less than one day
66	2	28	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Atty.

11. Industry or business

FATHER
12. Name Alfred J. Von Munchow
13. Birthplace Denton Md

MOTHER
14. Maiden Name Angie Smith
15. Birthplace Delaware

16 (a) Informant Robert L. Wilson
(b) Address 2915 Cremont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 18/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem. Location Pikesville Balto Co. Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1 East Eutaw Place

19 MAR 17 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1948, at 10[18] P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/14 1948, to 3/15 1948, and that I last saw him alive on 3/15 1948.

Immediate cause of death	Duration
Pulmonary Embolus	
Due to	
Due to Benign Prostatic Hypertrophy	
Other Conditions Lupus pubis cystotomy	

(Include pregnancy within 3 months of death)

Date of operation 3/14/48

Major findings of operation: Bladder filled = blood

of autopsy none.

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Benam M.D.

Address Balto. 1403 St. Date signed 3/15/48

VS 150

1296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 1296

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5829 Jonquil Ave D.O.A.
(c) Hospital or institution: 27-19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5829 Jonquil Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph J. Foreman

(b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Minnie M. Barefoot
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) 1/2/1891

8. AGE: Years	Months	Days	If less than one day
57	2	13	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Electrical appliances
11. Industry or business "

FATHER
12. Name Jos. Foreman
13. Birthplace Russia

MOTHER
14. Maiden Name Studa ?
15. Birthplace Russia

16 (a) Informant Mildred Foreman
(b) Address 5829 Jonquil Ave

17 (a) Burial (b) Date thereof Mch. 17/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem. Co.
Location Pikesville, Balto Co. Md

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place
Huntington Williams Mgr.

MAR 17 1948
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/15 1948 at 12:30 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Fabrigate M.D.
Medical Examiner.
Date signed 3/15/48

95 151

61297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. C61297

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2344 Stockton St
(c) Hospital or institution: 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL, and give town.)
(d) Street No. 2344 Stockton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie (Minnie) Green

(b) If veteran, name war none

3 (c) Social Security Account No. none

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Richard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/10/1880

8. AGE: Years 67 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace Calvert Co. Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Pinkney Green

13. Birthplace Calvert Co. Md

MOTHER 14. Maiden Name Mary Harris

15. Birthplace Calvert Co. Md

16 (a) Informant Indianna Young

(b) Address 1734 McCulloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director Geo. B. Kelson

(b) Address 1303 Pressman

19 (a) MAR 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 3 Mar 1948, at 1 32 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Earl L. Royer M.D. Medical Examiner

Date signed 14 Mar 48

To be approved by Medical Examiner

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181

Registered No. G61298

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: President Hospital 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 80 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1716 Division St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Irma Gibbs

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. No

6 (b) Name of husband or wife Clarence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/18/1911

8. AGE: Years 36 | Months 2 | Days 29 | If less than one day hr. min.

9. Birthplace Balto: Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John Peters
13. Birthplace md

MOTHER
14. Maiden Name Eleanor Shuffin
15. Birthplace md

16 (a) Informant Laura Peters
(b) Address 1716 Division St

17 (a) Burial (b) Date thereof 3/20/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director Wes. G. Kelson
(b) Address 1303 Pennsylvania

19 MAR 17 1948 (b) Huntingtown, Williams, Md
(Registered by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16 1948 at 6 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/26 1947 to 3/16 1948, and that I last saw h.er alive on 3/16 1948

	Duration
Immediate cause of death: Starvation and Hypo-proteinaemia	2 mos
Due to 2nd & 3rd degree burns of body and extremities	80 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident (Fire)
(b) Date of occurrence 12/26/47 at 9 00 P M
(c) Where did injury occur? Baltimore Md
(City or town) (County) (State)
14-6
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Burns (cigarette on bed)

23. Signature O. W. Hoffler
Address Provident Hosp Date signed 3/16/48

on p. 1 Wm. Hertford by Thomas J. Mackin, M.D.

299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a ✓

Registered No. C61299

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3013 Ferndale Ave
(c) Hospital or institution: 29-✓
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3013 Ferndale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Alida Boyle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7 1898

8. AGE: Years	Months	Days	If less than one day
49	8	9	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Harry F. Boyle
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Dora E. Smith
15. Birthplace Virginia

16 (a) Informant Harry W. Boyle
(b) Address 3013 Ferndale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 19 1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Harry A. Simmons
(b) Address 4204 Ridgewood Ave

1948 Mar 17 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 16 1948, at 1.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to March 1948 and that I last saw her alive on 3-15 1948.

Immediate cause of death	Duration
Carcinomatosis	
Due to Carcinoma of Cervix	6 mos.
Due to Secondary Anemia	1 yr.
Other Conditions Swelling of Left leg. Bloodless Ulcerated	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Hurst Jr M.D.
Address 4509 Liberty Heights Date signed 3-16

G61300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117B

G61300

Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11-3
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 Orchard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

(a) FULL NAME Elsie Mobley

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Howard J. Mobley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/9/1905

8. AGE: Years 42 | Months 10 | Days 7 | If less than one day hr. min.

9. Birthplace Oxford N. C. (Town, county, and state)

10. Usual Occupation Housemaid

11. Industry or business

FATHER
12. Name Henry Mayes
13. Birthplace N. C.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Howard J. Mobley
(b) Address 415 Orchard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore, Md.

18 (a) Funeral director Chas. R. Lee
(b) Address 802 Madison Ave

3-17-1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1948, at 4:00 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Generalized peritonitis due to perforation of duodenal ulcer

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D. (Medical Examiner)

Date signed 3-16-48

VS 151

G61301 ✓ G61301

BALTIMORE CITY HEALTH DEPARTMENT

Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 718 N. Fulton Ave.
(c) Hospital or institution: 16-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 718 N. Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ellen Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Negro	Widow

6 (b) Name of husband or wife Joseph Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16, 1885

8. AGE: Years	Months	Days	If less than one day
63	-	-	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Charles Johnson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Harriett E. Anderson
15. Birthplace Reistertown, Md.

16 (a) Informant Julia Johnson
(b) Address 1329 W. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 20, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 322 N. Schroeder St.

19 (a) Mar 1948 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1945, to March 11 1948, and that I last saw h... alive on March 15 1948.

Immediate cause of death	Duration
Coronary Occlusion	
Due to Arteriosclerosis	
Due to	
Other Conditions Congestive Failure	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Banzhaf
Address 722 N. Fulton Ave Date signed 3/16/48 M. D.

X

correct age if ascertained subsequently

VS 199

C61302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC: 48-05382 159

C61302
Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland 16-4
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2024 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

(a) FULL NAME Gary BURLEY

(b) If veteran, name war

(c) Social Security Account No.

3. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11, 1948.

8. AGE: Years | Months | Days: 3 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name James Burley
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Sarah Bell
15. Birthplace Bethlehem Pa.

16 (a) Informant Mrs. James Burley
(b) Address 2024 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 18 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) [illegible] 1948 (Date rec'd by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-13- 1948 at 10 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Prematurity
Partial atelectasis neonatorum.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.

Date signed 3/15/48

VS 191

G61303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 83a

G61303 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 730 George St
(c) Hospital or institution: 17-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 730 George St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME IDA T. HASKINS ROGERS

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. None

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 7/3/1885

8. AGE: Years 62 | Months 8 | Days 10 | If less than one day ... hr. ... min.

9. Birthplace Accomac Co. Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Satchell
13. Birthplace Va.

MOTHER
14. Maiden Name Maria ?
15. Birthplace Va

16 (a) Informant Ella Davis
(b) Address 730 George St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A. County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (a) Huntington Williams, M.D. (b) Registrar (Date received by registrar) MAR 17 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/13/48 1948 at 8:26 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-3 1948 to 3-10 1948 and that I last saw h alive on 3-13 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 10 dy
Due to: Arteriosclerosis
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 3-15-48

X

661304

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

661304 Registered No. 94a

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1813 Dukeman
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1134 W North St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

(a) **FULL NAME** Charles (Bowser) Bonar

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 24 1899

8. AGE: Years 49 | Months 0 | Days 23 | If less than one day hr. min.

9. Birthplace Noble Co Ohio (Town, county, and state)

10. Usual Occupation Grave Digger

11. Industry or business Lemmon & Lipmont Co

FATHER
12. Name Albert J Bonar
13. Birthplace Ohio

MOTHER
14. Maiden Name Ella Eddy
15. Birthplace W Va

16 (a) Informant Mrs Ira Bonar
(b) Address 620 S Fulton Ave

17 (a) Burial, cremation, or removal Funeral (b) Date thereof 3/19/48 (month) (day) (year)
(c) Cemetery or crematory Bellaire
Location Bellaire Ohio

18 (a) Funeral director Thelma Cox Off
(b) Address 2174 Pont St

MAR 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17 1948 2:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to h.s death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature R. J. Lehmann M.D. Medical Examiner.
Date signed 3/17/48

VS 131

G61305

BC-48-05646

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 157E

G61305 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2009 Eastlake St
(c) Hospital or institution: 20-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 Eastlake St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

1. (a) FULL NAME Baby Mitrogulco.
(b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 16, 1948
8. AGE: Years | Months | Days: 6 | If less than one day: hr. min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: None
11. Industry or business

FATHER
12. Name: Samuel Mitrogulco
13. Birthplace: Baltimore Md

MOTHER
14. Maiden Name: Rachel Leopold
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mr. Sam Mitrogulco
(b) Address: 2009 Eastlake St.

17 (a) Burial, cremation, or removal: Burial (b) Date thereof: 3/18/48 (month) (day) (year)
(c) Cemetery or crematory: Mount Calvary
Location: 4300 Old Frederick Rd.

18 (a) Funeral director: Blum Memorial Inc.
(b) Address: 1100-03 Pulaski St.

19 (a) 1948 (Date rec'd by registrar) (b) Registrar: Washington Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 19 48 at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1948 to March 16 1948 and that I last saw him alive on March 15 1948

Immediate cause of death: Pneumonia — Duration:
Due to:
Due to:
Other Conditions: Congenital Heart disease
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Milton Resenick M.D.
Address: 1429 W Fayette St. Date signed 3/16/48 M. D.

VS 150

109 B

G61306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

G61306 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17-1
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 924 Argyle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

1. (a) FULL NAME Roland Covington
(b) If veteran, name war
3 (c) Social Security Account No. 212-01-4128
4. Sex m
5. Color or race c
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife HILDA Covington
6 (c) If alive, give age 34 years
7. Birth date of deceased (mo., day, yr.) 1913
8. AGE: Years 35 Months Days If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Taylor
11. Industry or business

FATHER
12. Name Othel Hill
13. Birthplace Md.

MOTHER
14. Maiden Name Beatrice Bonds
15. Birthplace Md.

16 (a) Informant Hilda Covington
(b) Address 924 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cemetery
Location Md.

18 (a) Funeral director Leonard Waldron
(b) Address 7047 Myrtle Ave.

19 (a) Date 1948 (b) Registrar Huntington Williams

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16-48 19 , at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14 1948 to 3-16 1948, and that I last saw h in alive on 3-16 1948.

Immediate cause of death Reaction to Spinal Anesthetic — Duration
Due to Sensitivity to or Too rapid absorption of Procaine (Died before skin incision made) — Duration
Due to — Duration
Other Conditions — Duration
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 4/2
(a) Accident, suicide, or homicide
(b) Date of occurrence 3-16-48 at 7:45 P.M.
(c) Where did injury occur? Univ Hosp (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Univ Hosp (Specify type of place) While at work?
(e) Means of injury Anesthetic

23. Signature Ben Gold, M. D.
Address Univ Hosp Date signed 3-16-48

To be approved by Medical Examiner - Medical Examiner No. 8.

661307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

661307

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address North Broadway

(c) Hospital or institution: Church Home & Hosp. V-1

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d.

(e) Length of stay in Baltimore (yrs., mos., or days) 54 yr.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 211 N Kenwood Ave. (If rural give location)

(e) Citizen of foreign country? Non (Yes or No) If yes, name country

(a) FULL NAME Mr Joseph Kasprzak (KASPRZAK & KASPER)

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Ann Kasprzak

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) March 17 1894

8. AGE: Years 54 | Months 11 | Days 26 29 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business None.

FATHER 12. Name Stanislaus Kasprzak.

13. Birthplace Poland

MOTHER 14. Maiden Name Josefa Stacharanski

15. Birthplace Poland

16 (a) Informant Mrs Lonnie Skrzynski

(b) Address 1532 E Oath St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/18/48 (month) (day) (year)

(c) Cemetery or crematory HOLY ROSARY

Location GERMAN HILL ROAD

18 (a) Funeral director M. J. Padovski & Sons

(b) Address 1808 Eastern Avenue

(c) 3-17 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 19 48 at 8:22 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 12 19 48 to March 17 19 48 and that I last saw h[illegible] alive on March 14 19 48.

	Duration
Immediate cause of death: Cardiac decompensation.	2 yr.
Due to: Arteriosclerosis and chronic	10 yrs.
Due to:	
Other Conditions: Arteriosclerosis generalized	10 yrs.
Malnutrition.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Paul Bachand M. D.

Address Church Home & Hosp. Date signed 3/18/48

VS 150

G61308 ✓ G61308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 Braddish Ave
(c) Hospital or institution: 15-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Braddish Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Roger Lee Graft

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Dessa Graft
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1894

8. AGE: Years	Months	Days	If less than one day
55	4	12	hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)
10. Usual Occupation Chauffer
11. Industry or business

FATHER
12. Name John Graft
13. Birthplace Penn.

MOTHER
14. Maiden Name Maggie Small
15. Birthplace Penn.

16 (a) Informant Roger Graft, Jr.
(b) Address 1118 N. Lexington St.

17 (a) Burial (b) Date thereof 3-19-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Dalton Ave & Fayette St

(c) MAR 17 1948 Huntington Nottaway, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1948, at 3:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1948 to March 16 1948, and that I last saw h[illegible] alive on March 16 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	24 hrs.
Due to Arteria-sclerotic Cardio-renal Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Clinton Langfelder M. D.
Address 400 N. Payson St. Date signed 3/17/48

VS 150

X

C61309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

C61309 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3414 BANCROFT RD.
(c) Hospital or institution: — 27-W
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3414 BANCROFT RD. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME JOSEPH WASHINGTON MOORE

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: AMELIA KNOER MOORE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): JULY 6, 1865

8. AGE: Years 82 | Months 8 | Days 8 | If less than one day: hr. min.

9. Birthplace: ANNAPOLIS, MD. (Town, county, and state)
10. Usual Occupation: PHARMACIST
11. Industry or business: (RETIRED)

FATHER
12. Name: HENRY P. MOORE
13. Birthplace: MD.

MOTHER
14. Maiden Name: AMANDA J. DOLEY
15. Birthplace: MD.

16 (a) Informant: MRS. WM. A. FLAMM (DAUGHTER)
(b) Address: 3414 BANCROFT RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/17/48 (month) (day) (year)
(c) Cemetery or crematory: NEW CATHEDRAL
Location: BALTIMORE, MD.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: BALTIMORE, MD.

19 (a) Date received by Registrar: MAR 17 1948 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/14/1948, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/15 1948, to 3/14 1948, and that I last saw h alive on 3/13 1948.

Immediate cause of death: Coclusion, cranium

Due to: Carcinoma of stomach

Due to:

Other Conditions: A.S.C.V. Disease

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Howard Wilson, M.D.
Address: 5721 York Rd. Date signed 3/15/48

VS 150

G61310

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G61310
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Caton & Wilkens Aves
(c) Hospital or institution: St. Agnes Hospital No.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Dalethorpe (If outside city or town limits, write RURAL and give town)
(d) Street No. 4507 Ridge Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: Alma Grace Bloomberg

3 (b) If veteran, name war: —

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband ~~surviving~~: Maurice Bloomberg
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) June 6, 1894

8. AGE: Years	Months	Days	If less than one day
53	9	10	hr. min.

9. Birthplace: SEVERN - A.A. Co., MD. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Charles W. Anderson
13. Birthplace: A.A. Co, Md.

MOTHER
14. Maiden Name: Clara Paulus
15. Birthplace: GERMANY

16 (a) Informant: MR. MAURICE BLOOMBERG
(b) Address: 4507 RIDGE, R.D.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/19/48 (month) (day) (year)
(c) Cemetery or crematory: MEADOW RIDGE
Location: Balto Co., MD

18 (a) Funeral director: Wm J. Tickner & Sons
(b) Address: BALTIMORE, MD

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 17 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16 1948, at 8 55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1948 to March 16 1948 and that I last saw her alive on March 14 1948

Immediate cause of death	Duration
Cerebrovascular accident, left internal capsule	2 days
Due to Hypertensive cardiovascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation: none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Herbert J. Lenchos, M.D.
Address: St Agnes Hosp Date signed 3/16/48

X

G61311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G61311 Registered No.

1. PLACE OF DEATH: 24-2

(a) Baltimore City, Maryland

(b) Street address 1213 Light Street

(c) Hospital or institution: South Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1428 Jackson Street (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Howard Foote

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/29/1870

8. AGE: Years	Months	Days	If less than one day
77	10	16	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name George L. Foote

13. Birthplace Germ.

MOTHER 14. Maiden Name Anna Freund

15. Birthplace Germany

16 (a) Informant Family

(b) Address SAME

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 3-18-48 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Brooklyn

18 (a) Funeral director James L. McCauley

(b) Address 130 S. Fort Ave.

19 (a) (Date rec'd by registrar) (Name) Washington Funeral Home

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/15/48 19 , at 9:35 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/14 1948, to 3/15 1948, and that I last saw him alive on 3/15/48 19

Immediate cause of death	Duration
cardiac failure	1 day
Due to arteriosclerosis	
Due to	
Other Conditions urinary retention	2 da

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. D. Cooper M. D.

Address 1213 Light St. Date signed 3/15/48

X

VS 150

G61312

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G61342 Registered No. 171a

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 9-2
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1652 Round Hill Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

(a) **FULL NAME** Mary G. BORN HORN

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5-1885

8. AGE: Years 62 | Months 3 | Days 11 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name John Henry Born
13. Birthplace Germany

MOTHER
14. Maiden Name Philomina Albright
15. Birthplace Germany

16 (a) Informant Mrs. George Roth
(b) Address 1652 Round Hill

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto.

18 (a) Funeral director J. J. Luck
(b) Address 5305 Harford Rd.

(a) 7 1948 (b)
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16-1948 at 11 20 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull with intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-16-48 9-0 P 20 P. M.
(b) Where did injury occur? Harford Rd. near 32nd St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fell - struck by Street Car.

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 3/22/48

VS 191

G61313 Brawling ✓ G61313

BC-48-05880 159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 26-11
(b) Street address
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 S. Clinton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Brawling

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/15/48

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Norman Charles Brawling
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Georgette Stallings
15. Birthplace Baltimore, Md.

16 (a) Informant Norman C. Brawling
(b) Address 709 S. Clinton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location O'Donnell St.

18 (a) Funeral director Charles S. Briles
(b) Address 901 S. Conkling St.

MAR 17 1948 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1948, at 10:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/15 1948, to 3/16 1948, and that I last saw her alive on 3/16 1948

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible], M.D.
Address South Balt. Gen. Hospital Date signed 3/17/48

VS 150

X

G61314 ✓ G61314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 182B

BC-2 05676

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 26-11
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3238 Foster ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Elizabeth Coker

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 30, 1944

8. AGE: Years	Months	Days	If less than one day
3	7	15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Child.
11. Industry or business

FATHER
12. Name Joshua G. Coker
13. Birthplace Baltimore Co., Md.

MOTHER
14. Maiden Name Amelia Hessler
15. Birthplace Baltimore, Md.

16 (a) Informant Joshua G. Coker (Father)
(b) Address 3238 Foster Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-18-48. (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location 7401 Hernwood Hill Rd.

18 (a) Funeral director Charles S. Zeiler
(b) Address 901 S. Conkling St.

19 (a) MAR 17 1948 (b) (Date rec'd by registrar) Baltimore, Md. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 March 1948, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Pressure of heavy object on chest.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 15 Mar. 48 at 2. P. 26-11 M.
(b) Where did injury occur? 3238 Foster Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury Kitchen stove overturned on child

23. Signature Wm. H. Kammerer M.D. Medical Examiner
Date signed 15 Mar. 48

VS 181

G61315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

G61315 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Rome (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 Perry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary K. Crossman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-11-47

8. AGE: Years 1 | Months 13 | Days 6 | If less than one day hr. min.

9. Birthplace N.Y. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Mark Crossman

13. Birthplace N.Y.

MOTHER 14. Maiden Name Elizabeth Martin

15. Birthplace N.Y.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 19 48 (month) (day) (year)

(c) Cemetery or crematory St Peters

Location Rome N.Y.

18 (a) Funeral director Allen O. Mitchell Sons

(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Huntington Wm. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-16- 1948 to 3-17- 1948 and that I last saw h[illegible] alive on 3-17- 1948.

Immediate cause of death Intracranial Hemorrhage | Duration 13 hrs.

Due to Cerebral Hemorrhage

Due to Atelectasis

Other Conditions Traumatic Birth

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.

Address [illegible] Date signed 3-17-48

MAR 22 1948

VS 150

d: - No 3 Anchorage off Western Run Co.) (U. S. Coast Guard
Left Police Boat
G61 Chas. D. Haiche") BALTIMORE CITY HEALTH DEPARTMENT ✓ 1316
CERTIFICATE OF DEATH X 173 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution:
City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dor
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Temple
(If outside city or town limits, write RURAL and give town)
(d) Street No. Mount Laurel Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rudolph H. SCHONING

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 10, 1908

8. AGE: Years 40 | Months 2 | Days 6 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof March 17-48 (month) (day) (year)
(c) Cemetery or crematory Reading Penna
Location Pratt & B. M. Walker

18 (a) Funeral director
(b) Address Pratt & Fleet Sts.

19 MAR 17 1948 (Date rec'd by registrar) Temperature Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1948 at 6 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-24-48 26-06 M.
(b) Where did injury occur? Chesapeake Bay, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? at sea While at work? Yes
(d) Means of injury Drowning (Auto Crash)

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 3/17/48

VS 151

X

1317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. G61317

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 437 Manor Court
(c) Hospital or institution: 11-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 437 Manor Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby CASEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2-14-48

8. AGE: Years | Months | Days | If less than one day hr. 10 min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name ? Casey
13. Birthplace ?

MOTHER
14. Maiden Name Rena ?
15. Birthplace ?

16 (a) Informant Mrs. Rena Casey
(b) Address 437 Manor Court

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 15 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-14-1948 at 7 10 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2/14/48 (3) 10 P. M.
(b) Where did injury occur? 437 Manor Court
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? —
(d) Means of injury. Unattended

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 2/16/48

VS 191

61318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G61318

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5-0 Y
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1816 Low Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Mc Cready

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: MALE

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 52 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace ?

MOTHER
14. Maiden Name
15. Birthplace ?

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 15 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 17 1948 (Date rec'd by registrar) (Signature of Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5, 1948 at 8:55 A.M.

21. I certify that I took charge of the remains described above, held an INSPECTION thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Myocardial Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Hoyt M.D.
Medical Examiner.
Date signed 3-5-48

VS 181

1310 - 117903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G61319

PLACE OF DEATH:

1. Baltimore City, Maryland
2. Street address 4940 Eastern Ave.
3. Hospital or institution: Baltimore City Hospitals
4. Length of stay in hospital or inst. (yrs., mos., or days) 12 days
5. Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

1. (a) FULL NAME: Margaret Schumate
(b) If veteran, name war
3. (c) Social Security Account No.
4. Sex: F
5. Color or race: C
6. (a) Single, married, widowed, or divorced: Married
6. (b) Name of husband or wife: Wade
6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Nov. 2, 1888
8. AGE: Years 59 | Months 4 | Days 14 | If less than one day hr. min.
9. Birthplace: N. C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name: Daniel Rogers
13. Birthplace: N. C.

MOTHER
14. Maiden Name: Emma Rednum
15. Birthplace: N. C.

16. (a) Informant: B. C. H. Records
(b) Address: 4940 Eastern Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof March 1948 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary Cem
Location: A A County

18. (a) Funeral director: Mrs Rose A Elliott & Dt
(b) Address: 1948 N. Caroline St

19. MAR 18 1948 (Date rec'd by registrar) Per Keating for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 19 48 at 7.40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 4 19 48 to March 16 19 48, and that I last saw her alive on March 16 19 48.

Immediate cause of death: Uremia — Duration
Due to: Arteriolar Nephrosclerosis
Due to: Hypertensive Cardiovascular Disease
Other Conditions: Cerebral Thrombosis Recent
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: W. R. Dearborough M. D.
Address: Balto City Hosp Date signed 3-16-48

VS 193

132 Bur-3

BALTIMORE CITY HEALTH DEPARTMENT ✓ G61320
CERTIFICATE OF DEATH 52a
Registered No. 42607

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3218 Monona Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Satterfield
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	married

6 (b) Name of husband or wife Mary Satterfield
6 (c) If alive, give age 46 years
7. Birth date of deceased (mo., day, yr.) 9/15/01

8. AGE: Years	Months	Days	If less than one day
46 46 years	6	1	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Surgical Technician
11. Industry or business

FATHER
12. Name Charles Satterfield
13. Birthplace Md

MOTHER
14. Maiden Name Lillian Bussell
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 19-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director J. S. Waters & Son
(b) Address 3001 Kentucky Ave

19 MAR 18 1948 Huntington Wilkinson M.D. Registrar
(Date rec'd by registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16 1948, at 4:15 a M
21. I certify that death occurred on the date above stated; that I attended deceased from 1/6 1948 to 3/16 1948, and that I last saw him alive on 3/16 1948.

Immediate cause of death	Duration
Uremia	
Due to Renal Carcinoma with metastases	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1-17-48
Major findings of operation: Carcinoma left kidney
of autopsy Carcinoma, necrosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [illegible]
Address JHH Date signed 3-16-48 M. D.

X

61321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44B

Registered No. G61321

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Charles
(c) City or town La Plata
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Hearne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married.

6 (b) Name of husband or wife Ethel G.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) about 1903

8. AGE: Years	Months	Days	If less than one day
44	?	?	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation clerk.

11. Industry or business

FATHER
12. Name George Ernst
13. Birthplace Md.

MOTHER
14. Maiden Name Esther Parker.
15. Birthplace Md

16 (a) Informant Hospital Records
(b) Address University Hosp.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/48 (month) (day) (year)
(c) Cemetery or crematory
Location Salisbury Md.

18 (a) Funeral director Hunt & Ryan
(b) Address Waldorf Md.

19 (a) MAR 18 1948 (Date received by Registrar) Everington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17 1948, at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/7/47 to 3/17 1948 and that I last saw h[illegible] alive on 3/17 1948.

Immediate cause of death Cardiac Collapse

Due to Hodgkins Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H N Taylor M. D.
Address Redwood & Greene Date signed 3/17/48

VS 150

1322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 061322

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2810 Inglewood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2810 Inglewood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EMMA MARIE THOMPSON

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 219-01-8171

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: George Ross Thompson

6 (c) If alive, give age: 84 years

7. Birth date of deceased (mo., day, yr.): Sept. 12, 1864

8. AGE: Years 83 | Months 6 | Days 3 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Charles Burkert
13. Birthplace: Germany

MOTHER
14. Maiden Name: Barbara Schley
15. Birthplace: Germany

16 (a) Informant: George R. Thompson -
(b) Address: 2810 Inglewood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3/18/48 (month) (day) (year)
(c) Cemetery or crematory: Greenmount
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 MAR 18 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1948, at 12.12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 1948, to Mch 15 1948, and that I last saw her alive on Mch 14 - 1948.

Immediate cause of death	Duration
Chronic Myocarditis	5 yrs
Due to Cerebral Hemorrhage	1 mo
Due to	
Other Conditions Cerebral Arterio Sclerosis	5 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E North Ave Date signed 3/16/48

VS 150

1323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 467

Registered No. 1323

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Provident Hospital
(b) Street address 1519 Division Street
(c) Hospital or institution: Provident Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 Eislen Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/25/1900

8. AGE: Years	Months	Days	If less than one day
47	2	19	21 hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Harry Smith
13. Birthplace Balto

MOTHER
14. Maiden Name Charlotte Thomas
15. Birthplace Balto

16 (a) Informant Walter Gray Jr.
(b) Address 610 Eislen St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. G. Co., Md

18 (a) Funeral director Isaac L. Brown & Son
(b) Address 101 W Montgomery St.

19 MAR 18 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1948 at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/4/48 1948 to 3/15 1948, and that I last saw her alive on 3/15 1948.

Immediate cause of death	Duration
Secondary Shock	
Due to Malignancy of Rectum	
Due to	
Other Conditions Fibromyoma Uteri	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marcus W. Moore, M.D.
Address Prov. Gen. Hosp. Date signed 3/16/48

VS 130

X

1324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

Registered No. 661324

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 27
Hospital for the Women of Maryland.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 171 days
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3418 St. Ambrose Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Mary Curry

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Wh.	Wid.

6 (b) Name of husband or wife Howard W. Curry,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 3, 1871

8. AGE: Years	Months	Days	If less than one day
76	5	14	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Anton Krieger
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Kurtz
15. Birthplace Baltimore, Md.

16 (a) Informant Hospital Record.
(b) Address Lafayette & John Sts, City.

17 (a) Burial (b) Date thereof 3/20/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director MARTIN FAHEY & SONS
(b) Address 1827 W. North Ave.

19 (a) MAR 18 1948 (b) Certified from Williamsport, Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1948, at 12:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1947, to Mar 17 1948, and that I last saw her alive on Mar 16 1947

Immediate cause of death	Duration
Cardiac Failure	
Due to Toxemia	
Due to Carcinoma of the Bladder.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operations Oct 6; Oct 13, 1947.
Major findings of operation: Carcinoma of Bladder
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Carlton Hollowe M. D.
Address Hospital for Women of Maryland. Date signed

VS 159

61325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. 061325

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 209 E. 24th ST.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ABOVE ADDRESS 12 1 YR.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County -

(c) City or town BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 209 E. 24th ST.

(If rural give location)

(e) Citizen of foreign country? — (Yes or No)

If yes, name country —

3 (a) FULL NAME HARVEY G. DILLARD

3 (b) If veteran, name war WW #1

3 (c) Social Security Account No. Yes

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife NELLIE C. DILLARD

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 6, 1891

8. AGE: Years 56 | Months 10 | Days 10 | If less than one day ... hr. ... min.

9. Birthplace CLINTON, S. C.

(Town, county, and state)

10. Usual Occupation PAINTER

11. Industry or business GEO. M. SHENK.

FATHER 12. Name JACK DILLARD

13. Birthplace CLINTON, S. C.

MOTHER 14. Maiden Name UNKNOWN DAIR

15. Birthplace CLINTON, S. C.

16 (a) Informant MRS. NELLIE C. DILLARD

(b) Address 209 E. 24th ST.

17 (a) BURIAL (b) Date thereof 3/19/48

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory DAVID RIDGE

Location PIKESVILLE, MD.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address BALTIMORE, MD.

19 (a) MAR 18 1948 (b) — Registrar

(When filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16/48, at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 15, 1948 to March 16, 1948 and that I last saw him alive on March 16, 1948

Immediate cause of death	Duration
Coronary Occlusion.	1 Day
Due to Coronary Arteriosclerosis	?
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation None.

Major findings of operation: —

of autopsy: None.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at — M

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —

(Specify type of place)

(e) Means of injury —

23. Signature Frank M. Ogburn, M. D.

Address 2701 N. Calvert St. Date signed Mar. 17, '48.

VS 180

61326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G61326

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 715 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME WILLARD HAYNIE OWENS

3 (b) If veteran, name war: WWI
3 (c) Social Security Account No. 222-01-3186

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Ann Mixon Owens
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1892

8. AGE: Years	Months	Days	If less than one day
56	2	16	....hr. ....min.

9. Birthplace Reedville, Va.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Records & Goldsborough

FATHER
12. Name Willard Owens
13. Birthplace ?

MOTHER
14. Maiden Name Leah Bussells
15. Birthplace Deals Island, Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 18 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1948, 12:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 21 1948 to Mar. 17 1948, and that I last saw h. im alive on Mar. 17 1948.

Immediate cause of death	Duration
Empyema, chronic following pneumonectomy right side about five months ago	Unknown
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 3/17/48 M. D.

61327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. 61327

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2306 N. Fulton Ave
(c) Hospital or institution:

13-4

(d) Length of stay in hospital or inst. (yrs., mos., or days) ABOVE ADDRESS 52 YRS.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2306 N. FULTON AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME OTTO NEUMAN

3 (b) If veteran, name war: No
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife ANNIE M. C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 21, 1867

8. AGE: Years	Months	Days	If less than one day
80	11	26	27 hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation MACHINIST (RETIRED)
11. Industry or business CONTINENTAL CAN CO.

FATHER
12. Name ALBERT NEUMAN
13. Birthplace —

MOTHER
14. Maiden Name UNKNOWN
15 Birthplace "

16 (a) Informant MR. J. H. NEUMAN
(b) Address 604 N. CALVERT ST.

17 (a) BURIAL (b) Date thereof 3 19 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LORRAINE CEM.
Location WOODLAWN MD.

18 (a) Funeral director WILLIAM J TICKNER & SONS
(b) Address NORTH [illegible]

19 (a) MAR 18 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17 1948, at 2 35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 1948 to 3/16 1948
and that I last saw h[illegible] alive on 3/16 1948

Immediate cause of death	Duration
Edema of lungs	10 hrs.
Due to Cardiac failure	2 days
Due to Arteriosclerosis ch. & hypertension	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo E. Wells M. D.
Address 4100 Edmondson Date signed 3/18/48

VS 150

1328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G61328

Registered No.

PLACE OF DEATH:

1. Baltimore City, Maryland
2. Street address 2804 Roslyn Ave
3. Hospital or institution:

4. Length of stay in hospital or inst. (yrs., mos., or days) 15-8
5. Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2804 Roslyn Ave (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country —

(a) FULL NAME Rosa E. Eppler

(b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: MARRIED
(b) Name of husband or wife: Harry H. Eppler
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): MAR. 9, 1879
8. AGE: Years 69 | Months 0 | Days 7 | If less than one day ... hr. ... min.
9. Birthplace: Balto. MD. (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name: CHARLES H. BRANDT
13. Birthplace: GERMANY

MOTHER
14. Maiden Name: ROSA E. LOCKENMEYER
15 Birthplace: BALTIMORE, MD

16 (a) Informant: MR. HARRY H. EPPLER
(b) Address: 2804 Roslyn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/48 (month) (day) (year)
(c) Cemetery or crematory: HORRAINE
Location: Balto. Co., MD.

18 (a) Funeral director: Wm. J. Tickner & Sons
(b) Address: Baltimore, MD.

19 (a) MAR 18 1948 (Date rec'd by registrar) (b) Huntington Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16/48, at 10 15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/20 1946 to 3/16 1948 and that I last saw her alive on 3/16 1948.

Immediate cause of death: Carcinoma of Colon & metastasis to liver — Duration: 2 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Robert A. Reiter
Address: 340 E. Windsor Ave Date signed 3/18/48

VS 150

X

1329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. C61329

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 North Carey St.
(c) Hospital or institution: Good Samaritan Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 820 N. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Wheatley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Separated

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31-1909

8. AGE: Years 37 | Months 2 | Days 13 | If less than one day hr. min. 14

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Monmouth Rubber Co.

FATHER
12. Name Oscar Williams
13. Birthplace North Carolina

MOTHER
14. Maiden Name Edna Wheatley
15. Birthplace Cambridge Md.

16 (a) Informant Amos W. Wheatley
(b) Address 838 Bengenday

17 (a) (Burial, cremation, or removal) (b) Date thereof 3-18-1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Balto. Md.

18 (a) Funeral director Walter B. Spriggs
(b) Address 1809 W. Hamburg St.

19 MAR 18 1948 (Date rec'd by registrar) Hunting for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1948, at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 1948 to March 14 1948, and that I last saw him alive on March 14 1948

Immediate cause of death Carcinoma of Lung — Duration

Due to

Due to

Other Conditions Thrapeutic Tracheotomy
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stella Simpson

Address 27 North Carey Date signed 3/18/48

V S 150

1330 Carey

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 462

for Mrs. Grubb

Registered No. 61330

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 424 N. Duncan

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-3

(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 424 N. Duncan St (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3. (a) FULL NAME Mary Grubb

(b) If veteran, name war

(c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10, 1868

8. AGE: Years 79 | Months 7 | Days 6 | If less than one day: hr. min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER

12. Name Matthew Korpas

13. Birthplace Bohemia

MOTHER

14. Maiden Name Barbora Kohout

15. Birthplace Bohemia

16 (a) Informant Betty Steckrath

(b) Address 424 N. Duncan St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 19/48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore

18 (a) Funeral director Frank Coppadge

(b) Address 900 N. Chester St

19 (a) MAR 18 1948 (Date rec'd by registrar) (b) Entry for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1948 at 4:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from February 1948 to March 16 1948, and that I last saw her alive on March 16 1948

Immediate cause of death: Hypostatic Pneumonia — Duration 2-15-48

Due to: Carcinoma of Pancreas — 12 1/2 mo

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature William J. Kramer M.D.

Address 801 N Kenwood Ave Date signed 3/18/48

VS 190

061331
AB-79788

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. 061331

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940m Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

1. (a) FULL NAME George Barnes

(b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Widowed

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-1875?

8. AGE: Years	Months	Days	If less than one day
73?			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Peter Barnes
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 19-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem. Location Brooklyn, Md

18 (a) Funeral director Elroy D. Wilson
(b) Address 1100 Reisterstown Rd Baltimore, Md

19 MAR 18 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1948, at 2.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-12- 1943, to 3-16- 1948, and that I last saw him alive on 3-16- 1948.

Immediate cause of death: Cerebral Vascular Accident — Duration:
Due to: Hypertensive Osteosclerotic Cardio-Vascular Disease.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William H. Welsh M.D.
Address Balto City Hosp. Date signed 17 Mar 48

VS 150

1332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G61332

Registered No. 131a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 206 East St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 206 East St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Philip Jackson

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Widdow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 13 1862

8. AGE: Years 85 Months 3 Days 2 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Saloon

11. Industry or business

FATHER 12. Name James Jackson

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Mary Gaines

15. Birthplace Baltimore Md

16 (a) Informant Hazel Ambrose

(b) Address 216 East St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 18-1948 (month) (day) (year)

(c) Cemetery or crematory Mt Calvery Cem

Location Brooklyn Md

18 (a) Funeral director Elroy O Wilson

(b) Address 1010 Baltimore ave

MAR 18 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 1948, at 1:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 26 1948 to Jan. 26 1948 and that I last saw him alive on Jan. 26 1948.

	Duration Immediate
Immediate cause of death Coronary Occlusion.	
Due to Arterial Sclerosis - Glomerular nephritis - Cerebral Hemorrhage.	1
Due to Hypertension	
Other Conditions Nephritis - Mitral Insufficiency - Senile Cataracts.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at P M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J Harry Leeder

Address 14 E. Monument Date signed 3/17/48 M. D.

94a

VS 190

51333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

661333

Registered No. 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 217 N. Wolfe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-4
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 217 N. Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lewis Chavis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	col.	married

6 (b) Name of husband or wife Jeanette Chavis
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Sept. 15-1891

8. AGE: Years	Months	Days	If less than one day
56	6	1	hr. min.

9. Birthplace Florida
(Town, county, and state)

10. Usual Occupation Cement finisher

11. Industry or business

FATHER 12. Name unknown
13. Birthplace " "

MOTHER 14. Maiden Name unknown
15. Birthplace " "

16 (a) Informant Jeanetta Chavis
(b) Address 217 N. Wolfe St

17 (a) Burial (b) Date thereof 3-20-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem
Location Brooklyn Md

18 (a) Funeral director Elroy D. Wilson
(b) Address 1010 Bloomfield ave

19 (a) MAR 18 1948 (b) Registrar
(Not to be filled by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16 1948, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-16-1948 to 3-16-1948, and that I last saw h[illegible] alive on 3-16-1948.

Immediate cause of death	Duration
Acute myocarditis	1 day
Due to Lobar Pneumonia	2 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. L. Berry M. D.
Address 1420 E. Chase Date signed 3-17-48

VS 150

X

133 Vol. 1 LITZINGER X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136

G61334

Registered No. 44272

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Perrymans (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Richard Litzinger
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen Litzinger
6 (c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.) 12/30/20

8. AGE: Years	Months	Days	If less than one day
27 Years	2	19	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation General
11. Industry or business

FATHER
12. Name John Litzinger
13. Birthplace Md

MOTHER
14. Maiden Name Rachael Pierce
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 21. 1948 (month) (day) (year)
(c) Cemetery or crematory Sparrows
Location Perryman Md

18 (a) Funeral director Mabury Taneyhill Hoke
(b) Address Aberdeen Md

19 (a) MAR 18 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/18 1948, at 3:35 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/3 1948 to 3/18 1948, and that I last saw him alive on 3/18 1948.

Immediate cause of death	Duration
Hodgkins disease	6 mos?
Due to	
Due to	
Other Conditions Pulmonary tuberculosis (Include pregnancy within 3 months of death)	7 yrs.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Victor A. McKusick
Address Johns Hopkins Hosp. Date signed 3/18/48

VS 150

44 B

61335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. 61335

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1625 Mc Elderry St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 Mc Elderry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George E. Parker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-5-1896

8. AGE: Years 51 | Months - | Days 10 | If less than one day hr. min.

9. Birthplace Stausburg Pa
(Town, county, and state)

10. Usual Occupation Laundry man

11. Industry or business

FATHER
12. Name unknown
13. Birthplace " "

MOTHER
14. Maiden Name unknown
15 Birthplace " "

16 (a) Informant Nellie Dent
(b) Address 1625 Mc Elderry St

17 (a) Burial (b) Date thereof March 19-1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem
Location Brooklyn Md

18 (a) Funeral director Elroy B. Wilson
(b) Address 1010 Bentley ave

19 (a) MAR 18 1948 (b) Evington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15th 1948, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1948 to Mar 15 1948 and that I last saw h alive on 3/15 1948

Immediate cause of death Cerebral Hemorrhage — Duration 5 Days

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert R. Lafond M. D.
Address 822 N. Bond St Date signed 3/17/48

VS 150

X

61336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G61336

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1540 Aisquith St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1540 Aisquith St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida S. Perkins

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Ed. W. Perkins

6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1881

8. AGE:	Years	Months	Days	If less than one day
	67		23	hr. min.

9. Birthplace Baltimore - Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Alonzo Staylor

13. Birthplace Balto - Md

14. Maiden Name Sarah Eleason

15. Birthplace Balto - Md

16 (a) Informant Mr. Edward W. Perkins

(b) Address 1540 Aisquith St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Cemetery

Location 2930 Frederick Ave

18 (a) Funeral director Howard W. Blight Jr.

(b) Address 4914 Belair Road.

19 (a) MAR 18 1948 (Date rec'd by registrar) Lauriston Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1948, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1942 to March 16 1948, and that I last saw h. alive on March 15 1948.

Immediate cause of death

Hypertensive C-V disease — Duration 10 yrs.

Cardiac decompensation — 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. H. Strenger

Address 1402 E. Lanvale Date signed 3-18-48

V S 150

G61337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G61337 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3003 Northway Drive DOA.
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3003 Northway Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

1. (a) FULL NAME George Sanders

(b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Bruce Co.
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Sept 19 1884

8. AGE: Years 59 | Months 5 | Days 18 | If less than one day hr. min.

9. Birthplace Dorchester Co. (Town, county, and state)
10. Usual Occupation Fishermen
11. Industry or business Gen. Miller

FATHER
12. Name Riley Sanders
13. Birthplace Dorchester Co.

MOTHER
14. Maiden Name Clara Legg
15. Birthplace Dorchester Co

16 (a) Informant Mrs. Sanders (Wife)
(b) Address 3003 Northway Dr

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 19 48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director L. Diemann Son
(b) Address 6067 Harford Rd

19 MAR 18 1948 (Date rec'd by registrar) (b) Signature for Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17 1948, at 9:33 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive -
Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed 3/17/48

61338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. 61338

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1439 BATTERY AVE
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1439 BATTERY AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME TERESA . F FREEBURGER.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: FEM
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: DIVORCED

6 (b) Name of husband or wife: ALBERT FREEBURGER
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) OCT-17-1892

8. AGE: Years 56 | Months 45 | Days 0 | If less than one day: hr. min.

9. Birthplace BALTIMORE MD
(Town, county, and state)
10. Usual Occupation HOUSE WORK.
11. Industry or business AT HOME

FATHER
12. Name GEO J SCHMUCK.
13. Birthplace BALTIMORE MD

MOTHER
14. Maiden Name LOUISA P BOPP
15. Birthplace BALTIMORE MD

16 (a) Informant EDWARD F. FREEBURGER
(b) Address 1439 BATTERY AVE

17 (a) BURIAL (b) Date thereof 3-20-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location A. A - Co

18 (a) Funeral director Bernard C Harlow
(b) Address 121 E West St

19 (a) MAR 18 1948 (b) Huntington Wilkinson, MD
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH - 17 1948, at 12 04 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h[e] alive on 3/16 1948.

Immediate cause of death: Pneumonia

Due to: Metastasis to left lung

Due to: Carcinoma of Cervix

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 2 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R B Ellison M. D.
Address 107 E. West Date signed 3/21/48

VS 150

1339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 61339

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 535 S. Chapel Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-3
(e) Length of stay in Baltimore (yrs., mos., or days) 57 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 535 S. Chapel Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Michael Bentkowski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Katherine Bentkowski 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation retard
11. Industry or business

MOTHER / FATHER
12. Name Unknown
13. Birthplace Poland
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant John Bentkowski (Son)
(b) Address 2218 Portugal Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location Balto. County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) Huntington Williams M.D. Registrar
(Date Received) MAR 18 1948

MEDICAL CERTIFICATION 11 55

20. DATE OF DEATH March 16 1948, at P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 5 19 48 to March 16 19 48, and that I last saw him alive on March 16 19 48

Immediate cause of death	Duration
Hemiplegia	1 day
Cerebral Embolism	10 yrs.
Hypertension	
Senility	
Other Conditions Operation Myocarditis	5 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John F. Kyrdacker M. D.
Address 1302 Eastern Ave. Date signed 3/17/48

VS 150

837

61340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. 061340

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3703 Nortonia Rd.

(c) Hospital or institution: 15-9

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3703 Nortonia Rd.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

1. (a) FULL NAME: CHRISTINA LOUISE SHAFFER

(b) If veteran, name war: no

3 (c) Social Security Account No. no

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Franklin Shaffer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1866

8. AGE: Years 82 | Months 1 | Days 19 | If less than one day: hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Casper Haunert
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Tottebusch
15. Birthplace Germany

16 (a) Informant Mrs. Marie L. Shaffer
(b) Address 3703 Nortonia Rd.

17 (a) Burial (b) Date thereof 3/20/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 18 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 17, 1948, at 4:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/16 1947 to 3/17 1948
and that I last saw her alive on 3/17 1948

Immediate cause of death: Cerebral hemorrhage — Duration: 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Robert A. Reiter

Address 340 W Windsor Av Date signed 3/18/48

VS 150

X

51341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

Registered No. 48341

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3607 Callaway Ave.
(c) Hospital or institution: 15-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3607 Callaway Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: LUCY VERA WHEEDEN

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Howard Wheeden

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 11, 1876

8. AGE: Years: 71 | Months: 3 | Days: 6 | If less than one day: hr. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: John C. Woodland
13. Birthplace: Va.

MOTHER
14. Maiden Name: Lucy J. Teagle
15. Birthplace: Va.

16 (a) Informant: Mr. Howard Wheeden
(b) Address: 3607 Callaway Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 MAR 18 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 17, 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 1948 to Mar 17 1948, and that I last saw her alive on March 15 1948.

Immediate cause of death: Squamous cell carcinoma of scalp — Duration: 10 yrs.
Due to:
Due to:
Other Conditions: Anemia and cachexia
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Harry F. Klumpfel M.D.
Address 1101 St. Paul St. Date signed Mar 18.

VS 190

X

48-005699
G61342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G61342 / 157E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave. 20-3
(c) Hospital or institution St. Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County V. to A.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1914 Wilkens Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy Walters
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife
6 (c) If alive, give age 17 yrs.

7. Birth date of deceased (mo., day, yr.) Mar. 18 1948

8. AGE: Years | Months | Days | If less than one day 14 hr. 8 min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Albert Walters
13. Birthplace Md.

MOTHER
14. Maiden Name Agatha Kammer
15. Birthplace Md.

16 (a) Informant ALBERT W. WALTERS
(b) Address 1914 WILKINS AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 19-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director J. H. & B. M. Walters
(b) Address Pratt & Fremont Sts

19 (a) MAR 18 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1948, at 4:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17 1948 to 3/18 1948, and that I last saw him alive on 3/17 1948.

Immediate cause of death	Duration
CONGENITAL HEART - ATELECTASIS OF LEFT LUNG	
Due to CORRECTION OF AORTA PATENT DUCTUS ARTERIOSIS	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John N. Shaw M. D.
Address St. Agnes Hosp. Date signed 3/18/48

VS 150

X

61343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 61343

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2621 E. Chase St.
(c) Hospital or institution: 8-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2621 E. Chase St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marian J. Richardson
3 (b) If veteran, name war | 3 (c) Social Security Account No.
4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Charles H. Richardson | 6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb-29-1875
8. AGE: Years 73 | Months | Days 17 | If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business
MOTHER / FATHER
12. Name Alfred Coat
13. Birthplace England
MOTHER
14. Maiden Name Unknown
15. Birthplace
16 (a) Informant Mrs Hilda Pfaffer
(b) Address 2621 E. Chase St.
17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3-20-48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave
18 (a) Funeral director Toby & Miller Inc.
(b) Address 2425 E. Oliver St.
19 (a) 3-18-1948 (Date rec'd by registrar) (b) Huntington Pettigrew Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1948 at 6-15 P M
21. I certify that death occurred on the date above stated; that I attended deceased from March 17 1948 to March 17 1948, and that I last saw her alive on March 17 1948

Immediate cause of death: Apoplexy — Duration 1 hr.
Due to: Hypertensive Heart Disease — Duration ?
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature David Schumacher
Address 1101 N. Ureton Ave Date signed 3-17-48 M. D.

VS 150

61344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. C61344

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17-1
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 907 Pennsylvania Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Myrtle Nixon Adams

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Perry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28 1900

8. AGE:

Years	Months	Days	If less than one day
47	2	19	hr. min.

9. Birthplace Md. (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name James Nixon
13. Birthplace Md.

MOTHER
14. Maiden Name Lizzie ?
15. Birthplace Md.

16 (a) Informant Perry Adams
(b) Address 922 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

19 (a) MAR 18 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16-1948, at 3:45 P.M

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Royer M.D. Medical Examiner.
Date signed 3/17/48

VS 151

Dr. Krumrein
2822 Kenwood Ave.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1314

Registered No. C61345

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2827 Northern Parkway
(c) Hospital or institution: 27-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2827 Northern Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Emma Vickers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Langford A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1869

8. AGE: Years	Months	Days	If less than one day
78	6	28	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Isaac Newton
13. Birthplace Md.

MOTHER
14. Maiden Name Emma M. Slaughter
15. Birthplace Md.

16 (a) Informant Mr. Langford A. Vickers
(b) Address 2827 Northern Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-48 (month) (day) (year)
(c) Cemetery or crematory St. Paul's Cem.
Location Kent Co. Maryland

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, #14

19 MAR 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1948, at 9 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1948 to March 16 1948, and that I last saw her alive on March 16 1948.

Immediate cause of death: Uremia - Chronic Nephritis — Duration 3/12/48
Cardio-vascular-renal disease
Due to arterio-sclerosis —
Due to —
Other Conditions chronic arthritis —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Louis H. Krumrein M. D.
Address 2224 Kenwood Ave Date signed

VS 150

X March 17 48

346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G61346 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital ~~or Institution~~ St. Joseph's 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 hr. 35 min
(e) Length of stay in Baltimore (yrs., mos., or days) 13 hr. 35 min

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 514 E. Eager
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lookingbill, Baby Boy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1948

8. AGE: Years	Months	Days	If less than one day
			13 hr. 35 min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lookingbill, Charles William
13. Birthplace

MOTHER
14. Maiden Name Hornick, Mary Agnes
15. Birthplace Baltimore,

16 (a) Informant St. Joseph's Hospt
(b) Address Caroline St

17 (a) Burial (b) Date thereof 6/19/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director
(b) Address

19 MAR 18 1949 (b) Attesting for Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17, 1948, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 17 1948, to March 17, 1948, and that I last saw him alive on March 17, 1948.

Immediate cause of death Respiratory Failure — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Anthony F. DiPaula, M.D.
Address St. Joseph's Hosp Date signed 3/17/49

VS 150

Correct and sign in ink. Do not write in margin.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61347 ✓97 Registered No. 61347

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Lyndhurst St.
(c) Hospital or institution: 16-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1000 Lyndhurst St. (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles Henry Marshall

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Frances C. Marshall
6 (c) If alive, give age: 82 years

7. Birth date of deceased (mo., day, yr.): January 19, 1867

8. AGE: Years	Months	Days	If less than one day
81	1	29	hr. min.

9. Birthplace: Philadelphia, Pa. (Town, county and state)
10. Usual Occupation: Bookkeeper
11. Industry or business: Retired

FATHER
12. Name: Charles H. Marshall
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Frances ?
15. Birthplace: Pa.

16 (a) Informant: Frances C. Marshall
(b) Address: 1000 Lyndhurst St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-48 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Baltimore, Md.

18 (a) Funeral director: George L. Schwab
(b) Address: 2101 Frederick Ave.

19 (a) MAR 18 1948 (Date rec'd by registrar) (b) Huntington Woodmansee, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17, 1948, at 11:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1946 to 3-17 1948, and that I last saw h[illegible] alive on 3-17 1948.

Immediate cause of death	Duration
acute heart failure	
Due to arterio sclerosis and uremia	
Due to	
Other Conditions ✓	

(Include pregnancy within 3 months of death)

Date of operation ✓
Major findings of operation: ✓
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ (Specify type of place) While at work?
(e) Means of injury

23. Signature H W Schieve

Address H. W. SCHIEVE, M. D. Date signed 3/17/48 M. D.
3921 EDMONDSON AVE.
BALTIMORE-29, MD. X

VS 150

1348 Mbg 3

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G61348 / 96

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Del (b) County
(c) City or town Seaford (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Dolby
3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Alton Dolby
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 8/23/08

8. AGE: Years	Months	Days	If less than one day
39 years	6	26	hr. min.

9. Birthplace Del (Town, county, and state)
10. Usual Occupation Nurse
11. Industry or business

MOTHER / FATHER
12. Name Horace Short
13. Birthplace Del
14. Maiden Name Sarah C. Warrington
15. Birthplace Del

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 20/48 (month) (day) (year)
(c) Cemetery or crematory Odd Fellows Cem
Location Seaford Del

18 (a) Funeral director Wilhelm Funeral Home
(b) Address 208 Orleans St

19 MAR 18 1948 (Date rec'd by registrar) (b) Huntingtown Williamsport, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/18 1948, at 3 05 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 1948 to 3/18 1948, and that I last saw her alive on 3/18 1948.

Immediate cause of death	Duration
Subarachnoid hemorrhage	
Due to Cerebral aneurysm	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Mar. 17, 1948
Major findings of operation: Bloody ventricular fluid
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lowes H. Gerstle, M.D.
Address Johns Hopkins Hosp. Date signed Mar. 18, 48

VS 150

61349

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

Registered No. 61349

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Doctors Hospital 27-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3370 Shirley Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie GROSSFELD

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Samuel Grossfeld

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 15 1887

8. AGE: Years 60 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace Radom Poland
(Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

MOTHER

12. Name Isaac Surasew

13. Birthplace Radom Poland

FATHER

14. Maiden Name Rebecca Feinstein

15. Birthplace Radom Poland

16 (a) Informant DR. M. Grossfeld

(b) Address 3707 Belair Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 21/48 (month) (day) (year)

(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern ave

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124-26 W. North ave

19 (a) MAR 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-18- 1948, at 2-40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15 1948 to 3-16 1948; and that I last saw h- alive on 3-16 1948

Immediate cause of death Coronary Thrombosis

Due to

Due to Hypertension 1½ C.V.R.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Jinkins M.D.
Address 3370 Ewald Pl Date signed 3-18-48 M. D.

VS 150

61350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 61350

1. PLACE OF DEATH: 2476 Shirley Ave
(a) Baltimore City, Maryland
(b) Street address 2906 Loudon Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28-3 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2906 Loudon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME DOra Mendelson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Late Wilfred
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
72 71			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business House Wife

FATHER
12. Name Meyer Levinson
13. Birthplace Russia

MOTHER
14. Maiden Name Zelda ?
15. Birthplace Russia

16 (a) Informant Nathan Mendelson
(b) Address 2906 Loudon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 19, 1948 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) MAR 18 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1948, at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 9 1947, to March 18 1948, and that I last saw h.. alive on March 17 1948

Immediate cause of death: Cerebral Hemorrhage — Duration 3 days.
Due to Arteriosclerosis
Due to
Other Conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis V. Blum, M.D.
Address 230 Eutaw Pl. Date signed 3/18/48

V S 150

83a

61351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a ✓

Registered No. 61351

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 2109 Westwood Ave
(b) Street address 2109 Westwood ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 - 3

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 Westwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Esther Summers

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 80 | Months 7 9 | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Nathan Morscco
13. Birthplace Russia

MOTHER
14. Maiden Name Freda ?
15. Birthplace Russia

16 (a) Informant Mrs Gertrude Milliman
(b) Address 2109 Westwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 19, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) MAR 18 1948 (Date rec'd by registrar) (b) Signature of Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1948 at 2 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to March 18 1948, and that I last saw h[illegible] alive on March 17 1948.

Immediate cause of death: Coronary thrombosis — Duration: 4 weeks

Due to: arteriosclerosis — 10 yrs

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 1124 Eutaw Pl. Date signed 3/18/48

VS 150

61352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. 61352

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2628 Loyola Southway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1603 N Appleton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widow

6 (b) Name of husband or wife Kate Meyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Lithunia
(Town, county, and state)

10. Usual Occupation
11. Industry or business Housewife

FATHER
12. Name Louis Block
13. Birthplace Lithunia

MOTHER
14. Maiden Name Unknown
15. Birthplace Lithunia

16 (a) Informant Joseph Block
(b) Address 1603 N. Appleton St.

17 (a) Burial (b) Date thereof 3 19 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Anshei Emunah
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W. North Avenue

19 MAR 18 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1948, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1948 to 3-17 1948, and that I last saw h[illegible] alive on 3-17-48

Immediate cause of death
Acute Bronchial Asthma
Chronic Bronchial Asthma

Duration
March
5 years

Due to

Due to

Other Conditions Hypertension Cardiac Hypertrophy
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Theodore Cooper M. D.
Address 2201 Eutaw Place Date signed 3/17/48

V S 150

112

61353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 526

G61353 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hosp.
(c) Hospital or institution: Baltimore, Md. 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) life?

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 214 S. Conkling St
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME William Cosgrove

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Wh.	Married

6 (b) Name of husband or wife Mary J. Schmeiser
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Apr. 13 - 1877

8. AGE: Years	Months	Days	If less than one day
70	11	3	..... hr. ..... min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Thomas Cosgrove
13. Birthplace Balto., Md

MOTHER
14. Maiden Name Unk.
15. Birthplace "

16 (a) Informant Mrs. Mary J. Cosgrove
(b) Address 214 S. Conkling St

17 (a) Burial (b) Date thereof Mar. 19-1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Gay Cor. Ave.

18 (a) Funeral director Jno. J. Connelly
(b) Address 468 Eastern Ave.

19 (a) MAR 18 1948 (b) Signature for Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 (16) 1948 at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/18 1947 to 3/16 1948.
and that I last saw h[im] alive on 3/16 1948.

Immediate cause of death	Duration
Congestive heart failure	3 days
Pulmonary edema	
Due to arteriosclerotic heart disease	
Due to Carcinoma of urinary bladder, benign hyp. of prostate	1 yr.
Other Conditions nt. pyelonephritis	

(Include pregnancy within 3 months of death)
Date of operation 2/3/48, 2/17/48, 11/28/47.
Major findings of operation: Carcinoma of urinary bladder
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....
23. Signature Maurice Shapero M. D.
Address Sinai Hospital Date signed .....

VS 150

G61354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 134a

G61354 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 13 days
(e) Length of stay in Baltimore (yrs., mos., or days): 13 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Va. (b) County:
(c) City or town: Parksley
(If outside city or town limits, write RURAL and give town)
(d) Street No.: (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: OLIVER CROMWELL LEWIS

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lena ?
6 (c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): March 26, 1881

8. AGE: Years: 66 | Months: 11 | Days: 21 | If less than one day: ½ hr. min.

9. Birthplace: Parksley, Va.
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business:

FATHER
12. Name: Jones Lewis
13. Birthplace: Va.

MOTHER
14. Maiden Name: ? Shrieves
15. Birthplace: Va.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-19-48 (month) (day) (year)
(c) Cemetery or crematory: PARKSLEY CEMT
Location: PARKSLEY VA.

18 (a) Funeral director: John O Mitchell
(b) Address: 6910 Eastern Ave.

19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

MAR 18 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 18 1948, at 6:20A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 5 1948 to Mar. 18 1948, and that I last saw him alive on Mar. 18 1948.

	Duration
Immediate cause of death: Bilateral staghorn calculi	4 yrs
Other conditions: Coronary sclerosis	Unknown
Uremia, chronic	Unknown
Other Conditions: Pyonephrosis and pyelonephritis	4 yrs ✓

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury: None

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon
Address: Clinical Director Date signed 3/19/48 M. D.

X

G61355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

G61355 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Bel Air (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert R Richardson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: S
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) Aug — 1900
8. AGE: Years 47 | Months 7 | Days | If less than one day hr. min.
9. Birthplace Harford Co., Md (Town, county, and state)
10. Usual Occupation Cab Dispatcher
11. Industry or business

MOTHER / FATHER
12. Name C Chapman Richardson
13. Birthplace Md
14. Maiden Name Lotta Robinson
15. Birthplace Md

16 (a) Informant Charles R Richardson
(b) Address Bel Air, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 19/48 (month) (day) (year)
(c) Cemetery or crematory Union Chapel
Location Harford Co., Md

18 (a) Funeral director Joseph J Slater
(b) Address Bel Air Md

19 (a) Mar 20 1948 (Date rec'd by registrar) (b) Courtenay Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-17 1948, at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-16 1948 to 3-17 1948, and that I last saw him alive on 3-17 1948.

Immediate cause of death	Duration
Acute Hemorrhagic Pancreatitis	
Due to	
Due to	
Other Conditions Hypertrophy Myocardium Cholecystitis & Adhesions (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Acute Hemorrhagic pancreatitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ben Gold M. D.
Address Univ Hosp Date signed 3-18-48

VS 150

124

1356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G61356
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lewis Hosp. 17-1
(c) Hospital or institution: Greene & Lombard St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 426 W Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Albert Howell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race Wh. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1884

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER / FATHER

12. Name William Howell

13. Birthplace England

MOTHER

14. Maiden Name Montgomery Grogan

15. Birthplace Md.

16 (a) Informant Hosp records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director J. J. Lahey & Sons

(b) Address 208 Lexington St.

MAR 19 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-13 1948, at 7:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-9 1948 to 3-13 1948 and that I last saw h. alive on 3-13 1948

Immediate cause of death Cardiac failure

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard E Hall M. D.

Address Lewis Hosp Date signed 3-18-48

VS 150

357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G61357

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Dundalk Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 125 Sollers Pt Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew J. Evans

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23 - 1871

8. AGE: Years 76 | Months 7 | Days 24 | If less than one day: hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " " "

MOTHER
14. Maiden Name Unknown
15. Birthplace " " "

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-48 (month) (day) (year)
(c) Cemetery or crematory
Location Fayetteville N. C.

18 (a) Funeral director Samuel W. Sullivan Jr.
(b) Address 1011 N. Arlington Ave.

MAR 19 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-17-1948 at 4 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-16-1948 to 3-17-1948 and that I last saw h[illegible] alive on 3-17-1948

	Duration
Immediate cause of death: Carcinomatosis	
Due to: Carcinoma of bladder	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Inoperable Carcinoma bladder
of autopsy: Carcinomatosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Peter P. Seadrie M. D.
Address [illegible] Date signed 3-18-48

1358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 661358

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1407 East Gough
(c) Hospital or institution: 3-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 East Gough (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AUGUSTA HELEN ULRICH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband ~~or wife~~: John Ulrich

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 8th 1884

8. AGE: Years 64 | Months 1 | Days 9 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name John Essert
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Cushman
15. Birthplace Unknown

16 (a) Informant John Ulrich
(b) Address 1407 Gough St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/20/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto.
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1207 St. Paul St.

19 MAR 19 1948 (Date rec'd by local Registrar) Huntington Williams M.D. Registrar

VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17/48 19 , at 11:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John L Davis M.D. Medical Examiner.
Date signed 3/18/48

G61359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

Registered No. G61359

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 82 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No. Old Annapolis Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Henrika~~ Henrika Maria Johanna de Vogel

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Harry de Vogel
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) 20 November 1886

8. AGE: Years	Months	Days	If less than one day
61	3	27	hr. min.

9. Birthplace Holland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Johannes Verstegen
13. Birthplace Holland

MOTHER
14. Maiden Name Maria Johanna Verschuren
15. Birthplace Holland

16 (a) Informant Husband
(b) Address Pasadena, Maryl

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 MAR 19 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-17 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 27 Nov. 1947, to 17 March 1948, and that I last saw her alive on 17 March 1948

Immediate cause of death Mesenteric thrombosis (recurrent) — Duration

Due to Arteriosclerosis, generalized

Due to

Other Conditions Gastrectomy

(Include pregnancy within 3 months of death)

Date of operation 27 Nov 47

Major findings of operation: Mesenteric thrombosis

of autopsy: Gangrenous intest

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Rosin M. D.
Address West Bal. General Hosp. Date signed 17 March

correct age is especially important

VS 150

61360
B-114412

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 309

Registered No. 61360

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26-17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Charles Lankford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6-1900

8. AGE: Years	Months	Days	If less than one day
47	7	10	hr. min.

9. Birthplace Philadelphia, Pennsylvania
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name George Lankford
13. Birthplace Virginia

MOTHER
14. Maiden Name Lucy ?
15. Birthplace Washington, D.C.

16 (a) Informant Records, Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-23-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

MAR 19 1948 (Date of death) (Registrar) Lustrington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16- 1948, at 1.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-10- 1947 to 3-16- 1948, and that I last saw him alive on 3-16- 1948

Immediate cause of death	Duration
Bronchopneumonia	1 wk
Due to	
Due to	
Other Conditions Malaria Anti-luetic Therapy (Include pregnancy within 3 months of death)	1 mo

Date of operation

Major findings of operation:

of autopsy: to be done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. E. Robinson Jr
Address Balt City Hosp Date signed 3/18/48 M. D.

VS 150

107

61361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. 61361

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address South Balto. Hosp
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) D.O.A.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County B.A.
(c) City or town Curtis Bay #26
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Desreaux ~~Bell~~ V. Bell

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-0008

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of ~~husband~~ or wife Maria Bell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12 1899

8. AGE: Years	Months	Days	If less than one day
48	9	4	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Construction Iron Worker
11. Industry or business Dawson Chemical Co

FATHER
12. Name Edward W. Bell
13. Birthplace Virginia

MOTHER
14. Maiden Name Virginia Crew
15. Birthplace Virginia

16 (a) Informant Mrs. Earl C. Smith
(b) Address 125 Hawkins Pt Rd. - 26

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/48 (month) (day) (year)
(c) Cemetery or crematory Glenburnie Cem
Location Glenburnie Md

18 (a) Funeral director Milton Schilling
(b) Address 3914 Hanover St. 25

MAR 19 1948 (Date rec'd by registrar)

Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH March - 16 1948, at 4:25 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Artery Arteriosclerosis, Aneurism, Hypertrophy & Dilatation of Heart

Due to

Other Conditions Acute Pulmonary Edema

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 3/17/48

VS 151

1362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 61362

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3804 W. Rogers Ave
(c) Hospital or institution: 27-19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3804 W. Rogers Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Milton P. Lewis

3 (b) If veteran, name war —

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	W.

6 (b) Name of husband or wife Bertha Shipley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1875

8. AGE: Years	Months	Days	If less than one day
72	6	5	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Retired Gas & Electric Co.

11. Industry or business Personal Dept.

FATHER 12. Name George Lewis

13. Birthplace England.

MOTHER 14. Maiden Name Unknown

15. Birthplace England.

16 (a) Informant Mrs. Milton P. Lewis

(b) Address 3804 W. Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-48 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville, Md.

18 (a) Funeral director Loring Bogley

(b) Address 5005 Park Heights Ave

19 (a) MAR 19 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1948, at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 28 1947 to Mar 16 1948, and that I last saw him alive on Mar 16 1948.

Immediate cause of death	Duration
Coronary Thrombosis	3.16.48
Due to Arteriosclerosis	?
Due to Diabetes	1947
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D. Seibert M.D.

Address 4803 Park Heights Ave Date signed 3/19/48

V S 150

Correct age is especially important

61363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 61363

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3616-17 Chestnut Ave.
(c) Hospital or institution: 13-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 839 Pavera St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kate V. Neal.

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Irwin W. Neal Sr.
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1886

8. AGE: Years	Months	Days	If less than one day
61	3	22	hr. min.

9. Birthplace Md. (Town, county and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name George Hale.
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Snyder.
15. Birthplace Md.

16 (a) Informant Irwin W. Neal Sr.
(b) Address 839 Pavera St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 22 1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn.
Location Woodlawn, Md.

18 (a) Funeral director Paul E. Schmeusser & Son
(b) Address 3615-17 Chestnut Ave.

19 (a) MAR 19 1948 (Date rec'd by registrar) Registrar for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 18 1948, at 1:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947, to Mar 18 1948, and that I last saw her alive on Mar 18 1948.

Immediate cause of death	Duration
Due to Hypertension —	
Cardio-vascular —	
Due to renal disease	
Other Conditions	
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lloyd E. Saylor M. D.
Address 3902 Greenmount Ave Date signed Mar 19 48

VS 150

X

61364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No. 61364

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 3/4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 308 2nd Ave. Glen Burnie (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Doggendorf

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-5694

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Anna Stepanuk
6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) Jan. 8 1909

8. AGE: Years	Months	Days	If less than one day
39	2	10	hr. min.

9. Birthplace Hungary - Austria (Town, county, and state)
10. Usual Occupation Burner
11. Industry or business Bethlehem Steel - Key Highway

FATHER
12. Name Nicola Doggendorf
13. Birthplace Austria Hungary

MOTHER
14. Maiden Name Anna Doggendorf
15. Birthplace Austria Hungary

16 (a) Informant Mrs. Anna Doggendorf
(b) Address 308 2nd Ave. Glen Burnie

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 20 48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cemetery
Location Patapsco Highway

18 (a) Funeral director Krause Funeral Home
(b) Address 214 E. Charles St

19 (a) MAR 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1948, at 4:57 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 18 1948 to March 18 1948, and that I last saw him alive on March 18 1948.

	Duration
Immediate cause of death: Pulmonary Edema	6 hours
Due to: Right ventricular cardiac failure	6 hours
Due to: Hypertensive Cardiovascular Disease	? years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alfred H. Damm M. D.
Address Maryland General Hospital Date signed 3/18/48
for Dr. J. Sukowski by X Howard T. Maddox, M.D.

661365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 661365

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 502 Laurens St.
(c) Hospital or institution: 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 Laurens St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Compton Makel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1876

8. AGE: Years 72 | Months 1 | Days 5 | If less than one day: hr. min.

9. Birthplace Calvert Co. Md. (Town, county, and state)

10. Usual Occupation Butler

11. Industry or business

MOTHER / FATHER

12. Name Daniel Makel

13. Birthplace Calvert Co. Md.

14. Maiden Name Angelina Smallwood

15. Birthplace St. Marys Co. Md.

16 (a) Informant Mrs. Milly Makel

(b) Address 502 Laurens St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mrs. Lee A. Hulbert

(b) Address 1631 Druid Hill Ave.

19 MAR 19 1948 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16- 1948, at 6.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 1948 to 3/16 1948 and that I last saw h— alive on 3/16 1948.

Immediate cause of death Cardiac - Renal — Duration: 1 Mo 6 Days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. N. Hatcher

Address 17 W. Pratt Date signed 3/19/48

correct age is especially important

VS 150

G61366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G61366

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 26-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dom
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name)
(d) Street No. 3327 E. Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JACOB BECK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary E. Beck

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-24-1868

8. AGE: Years 79 | Months 11 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Jacob Beck
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown.

16 (a) Informant Mary E. Beck
(b) Address 3327 E. Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-48 (month) (day) (year)
(c) Cemetery or crematory Woodland Memorial
Location Taylor Avenue

18 (a) Funeral director Frederick D. Miller, Jr.
(b) Address 3098 Monument St

19 (a) MAR 19 1948 (Date rec'd by registrar) (b) Huntington Nitkamp, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-17 1948, at 7 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis

Due to

Other Conditions Fracture of skull.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 3/17/48

X

1367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C61367

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Raynor Ave
(b) Street address
(c) Hospital or institution — West Balto Gen 16-T
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Week
(e) Length of stay in Baltimore (yrs., mos., or days) 73 11 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1133 Ashburton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME KATIE B DIENSTBACH

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Harry J Diensbach | 6 (c) If alive, give address

7. Birth date of deceased (mo., day, yr.) APR 16 1874

8. AGE: Years 73 | Months 11 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER
12. Name Thos Wheatley
13. Birthplace Not Known

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Mrs E. Augustine
(b) Address 1133 Ashburton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Frederick Ave

18 (a) Funeral director Geo. H. Kelmbach
(b) Address 1211 N. Lynnhurst St

19 (a) MAR 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1948, at 9:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-11- 1948 to 3-18 1948 and that I last saw HER alive on 3-18 1948

Immediate cause of death CARDIAC FAILURE — Duration

Due to ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to

Other Conditions VENTRAL ADDOMINAL HERNIA (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Augustine, M.D.
Address W. Baltimore General Hosp. Date signed 3/19/48

VS 150

61368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G61368

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 Shields Alley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward J. Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 31 1901

8. AGE: Years 46 | Months 6 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Edward Jones
13. Birthplace Md

MOTHER
14. Maiden Name Amelia Grimes
15. Birthplace N.J.

16 (a) Informant Mrs. Mary Jones
(b) Address 1127 Shields Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mem Park
Location Balto Co., Md.

18 (a) Funeral director Morgan & Millard
(b) Address 548 W. Biddle St.

19 MAR 19 1948 (Date rec'd by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1948, at 7 A.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary edema

acute alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner

Date signed 3-18-48

VS 151

61369

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G61369 / 167

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5-1
(c) Hospital or institution: Johns Hopkins Hospital Don
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 Mulligan Street (If rural give location)
(e) Citizen of foreign country? MULLIKEN (Yes or No) If yes, name country

3 (a) FULL NAME Benjamin Pickens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years	Months	Days	If less than one day
42			hr. min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Harry Pickens
13. Birthplace Brownsville, Penna.

MOTHER
14. Maiden Name Alice McMiller
15. Birthplace Chambersburg, Penna.

16 (a) Informant Chatman Funeral Home
(b) Address York, Penna.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-48 (month) (day) (year)
(c) Cemetery or crematory
Location York, Penna.

18 (a) Funeral director Mrs. Frances A. Remsley
(b) Address 578 W. Biddle St.

19 (a) MAR 19 1948 (Date rec'd by registrar) (b) Thornton Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-18-1948, at 6 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-18-48 at A.M.
(b) Where did injury occur? 1306 Mulligan Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? NO
(d) Means of injury Sharp Instrument

23. Signature Carl M. Peyser M.D. Medical Examiner.
Date signed

VS 181

61370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G61370

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N Carey St
(c) Hospital or institution: Good Samaritan Home 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 Pierce st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Hawkins

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/20/1888

8. AGE: Years	Months	Days	If less than one day
59	3	16	hr. min.

9. Birthplace Laurel Md
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

MOTHER—FATHER
12. Name Charlie Emerson
13. Birthplace Md
14. Maiden Name Daddie American
15. Birthplace

16 (a) Informant Ethel Robinson
(b) Address 8323-169th JAMAICA N.Y.

17 (a) Burial (b) Date thereof 3-20-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Mt. Auburn

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania Ave

19 (a) MAR 19 1948 Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1948, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 13 1948 to March 16 1948 and that I last saw h[illegible] alive on March 16 1948

Immediate cause of death Malnutrition — Duration 6 months
Due to Cardiac failure
Due to Anemia — over
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 27 N. Carey St. Date signed March 16 1948

correct age if apparently improbable

V S 150

Stelio Dompreschi

1371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. GG1371

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 26-4
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5917 Pulaski Hiway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas GREEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/2/1890

8. AGE: Years	Months	Days	If less than one day
58	3	7	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William Green
13. Birthplace Va.

MOTHER
14. Maiden Name Rosa Allen
15. Birthplace Va.

16 (a) Informant Carrie Quackenbush
(b) Address 731 Sterling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. County

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St.

MAR 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1948, at 8 30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑; accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pyelonephritis
Cystitis
~~Due~~ Myocardial hypertrophy, dilatation, and degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] G. Merrill M.D. Medical Examiner.
Date signed 3/9/48

VS 151

1372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. 661372

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 227 N. Fulton Ave.
(c) Hospital or institution: 19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 227 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas H. Nelson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	married

6 (b) Name of husband or wife Wilhemina Nelson.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1868

8. AGE: Years	Months	Days	If less than one day
79	10	12	hr. min.

9. Birthplace Middlesex Co., Virginia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name James Nelson.
13. Birthplace Virginia

MOTHER
14. Maiden Name Eliza
15. Birthplace Virginia

16 (a) Informant Amos Nelson.
(b) Address 913 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-1948. (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Miss Katie R. Williams
(b) Address 1932 N. Edmondson Ave.

19 (a) MAR 19 1948 Huntington Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1948 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1948 to March 17 1948, and that I last saw h alive on March 17 1948.

Immediate cause of death	Duration
Pulmonary Edema	2 days
Due to Myocardial Failure	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Woodland M. D.
Address 1 E. Fayette Date signed March 19 1948

CHARLES WOODLAND

VS 150

G61373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G61373 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1007 Leadenhall Street
(c) Hospital or institution: 23-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-30, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 Leadenhall Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Gross

3 (b) If veteran, name war ------
3 (c) Social Security Account No. -----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Mary Gross
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June-3, 1886

8. AGE: Years	Months	Days	If less than one day
61	9	13	hr. min.

9. Birthplace Calvert Co., Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William Gross
13. Birthplace Maryland

MOTHER
14. Maiden Name Eliza ?
15. Birthplace Maryland

16 (a) Informant Viola Johnson (D)
(b) Address 1006 Warmer Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co., Maryland

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) Date rec'd by registrar 3-19-48 (b) Registrar Huntington Williams M.D.

correct age if apparently inaccurate

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1948, at 4-A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 6, 1948 to March 16 1948. and that I last saw him alive on March 15, 1948.

Immediate cause of death	Duration
Arteriosclerosis	
Due to	
Due to	
Other Conditions Malnutrition, extensive decubiti	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. R. Campbell M. D.
Address 718 Dolphin St. Date signed 3-17-48

G61374

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 52B

G61374
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17 N. Wickam Road
(c) Hospital or institution: 284
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 17 North Wickam Road
(If rural give location)
(e) Citizen of foreign country? No a (Yes or No)
If yes, name country

3 (a) FULL NAME KATIE SCHELLER

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-1516

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ernest Scheller
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) 21 June 1874

8. AGE: Years 74 | Months 8 | Days 24 25 | If less than one day: hr. min.

9. Birthplace: Baltimore Maryl nd
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: At Home

MOTHER / FATHER

12. Name: Wilhelm Borchers

13. Birthplace: Germany

14. Maiden Name: Gesine M. Oetken

15. Birthplace: Germany

16 (a) Informant: Mrs. Frank Jurak (Daughter)
(b) Address: 17 N. Wickam Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 19 Mar. 48 (month) (day) (year)
(c) Cemetery or crematory: WESTERN CEMETERY
Location: BALTIMORE MARYLAND

18 (a) Funeral director: F.B.WIPPERT & SON
(b) Address: 1300 EUTAW PLACE 17

19 (a) Date 1948 (b) Registrar

MAR 19 1948

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16th. 1948 7:30P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1/48 1948 to 3/16 1948 and that I last saw her alive on 3/15/48 1948.

Immediate cause of death: Carcinoma of Bladder — Duration 1 M Days

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. McCollins M. D.

Address Frederick Ave. Date signed 3/17/48

Dr. Collins. X

61375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. 61375

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address South Balto. Gen. Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore ST DENIS
(If outside city or town limits, write RURAL and give town)
(d) Street No. [illegible] (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leo Conway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	M. [illegible]

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31- 1889

8. AGE: Years	Months	Days	If less than one day
58	7	17	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Nathaniel Conway
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Bridget Pendergrass.
15. Birthplace Baltimore - Md.

16 (a) Informant Mrs Dorothy Till
(b) Address 2607 Tulip Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Tippett & Tierney
(b) Address 1426 Light St.

19 (a) [illegible] (Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1948, at 3:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 7, 1948 to March 17 1948 and that I last saw him alive on March 15 1948.

Immediate cause of death Respiratory Failure — Duration 3 hrs.

Due to Intracranial hemorrhage, — Duration 5 days

Due to Hypertensive arterio-sclerotic cardiovascular dis. — Duration 5 yrs.

Other Conditions Coronary thrombosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gilbert M. Carouge M. D.
Address 6226 Everall Ave. Date signed 3-18-48

correct age is especially important. Physicians, please

VS 150

61376

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 193a

G61376
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 378 Mt. Olivet Lane
(c) Hospital or institution: 20-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 378 Mt. Olivet Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adam Nash

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo.) (day) (year) or how long alive if less than one day

8. AGE: Years	Months	Days	If less than one day
About 64			hr. min.

9. Birthplace Chicago (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Nash
13. Birthplace Chicago

MOTHER
14. Maiden Name Kathleen Corbett
15. Birthplace Unknown

16 (a) Informant Louis Nash
(b) Address 4127 Morrison Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 19, 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location G. Ave. & Mt. Olivet

18 (a) Funeral director Hyman Fleming
(b) Address 1426 Light St.

19 (a) MAR 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/18/48 19 , at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/16/48 19 to 3/18/48 19 , and that I last saw him alive on 3/16/48 19 .

Immediate cause of death Myocardial Acute — Duration: 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. H. Horton, M.D.
Address 1 E. Eden Ave. Date signed 3/18/48

VS 153

X

1377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. C61377

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert 137
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Emergency to accident ward
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3817 Falls Rd
(If rural give location)
(e) Citizen of foreign country? [illegible] (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Carrie Elizabeth Combs

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Married

6 (b) Name of husband or wife Eli Norris Combs
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Feb. 2-1892

8. AGE: Years	Months	Days	If less than one day
56	1	17	..... hr. ..... min.

9. Birthplace Tobensville Baltimore C. Balt. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Daniel Palmer
13. Birthplace Maryland

MOTHER
14. Maiden Name Myers
15. Birthplace Maryland

16 (a) Informant Mrs. Lillian G. Young
(b) Address 3817 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 22-1948 (month) (day) (year)
(c) Cemetery or crematory St. Mary's (Hampden)
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 MAR 19 1948 (Date rec'd by registrar) (b) Tunstall Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19 1948, at 12:56 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-13 1948 to 3-19 1948, and that I last saw her alive on 3-19 1948.

Immediate cause of death	Duration
Acute Congestive heart failure	
Due to Hypertensive heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel W. Bell M.D.
Address Union Memorial Hosp. Date signed 3-19-48

VS 150

Correct age is especially important

1378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. G61378

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution: University Hosp. 2-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 707 W. Hamburg St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence M Garland

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Herbert Garland

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1900

8. AGE: Years 47 | Months 11 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business at home

MOTHER / FATHER

12. Name Robert L. Powell

13. Birthplace Baltimore Md.

14. Maiden Name Mary Hockelbee

15. Birthplace Baltimore Md.

16 (a) Informant Mrs Herbert Garland

(b) Address 707 W Hamburg St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/48 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet Cem

Location 2330 Frederick Ave

18 (a) Funeral director John J. Cowan & Son

(b) Address 701-03 Hollins St.

19 MAR 19 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-18 1948 at 1 P. M

21. I certify that I took charge of the remains described above, held an INSP. & INQUIRY thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to HER death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Illuminating Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/18/48 at ? A. M.
(b) Where did injury occur? 707 W. Hamburg St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Inhalation of Illuminating gas (4 burners turned on)

23. Signature Howard J. Madden M.D.
Medical Examiner.

Date signed 3/18/48

VS 181

61379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12/a

Registered No. G61379

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 961 Rosedale St.
(c) Hospital or institution: 16-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Rosedale St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VANCE C. KEEFER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Birdie Keefer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 22, 1885

8. AGE: Years	Months	Days	If less than one day
62	6	25	hr. min.

9. Birthplace Carroll Co., Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business James Keelty Real Estate

FATHER
12. Name Charles Keefer
13. Birthplace Carroll Co., Md.

MOTHER
14. Maiden Name Anna Barth
15. Birthplace Carroll Co., Md.

16 (a) Informant Mrs. Birdie Keefer
(b) Address 961 Rosedale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 20, 1948 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 19 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 17, 1948, at 4:35P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 11 1948 to March 17 1948, and that I last saw him alive on March 16 1948

Immediate cause of death Cerebral hemorrhage arterio sclerotic type heart disease — Duration 4 days

Due to Generalized arterio sclerosis with hypertension — Duration Several years

Due to — Duration

Other Conditions Chronic nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Michel M. D.
Address 2901 Edmondson Ave Date signed March 18, 48

93D

VS 150

61380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. G61380

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Pk. Drive & 31st St.

(c) Hospital or institution: US Marine Hospital 8-1

(d) Length of stay in hospital or inst. (yrs., mos., or days): 8 days

(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County:

(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No.: 3220 Belair Rd.
(If rural give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: CHARLES EDWARD SHOOK

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No.: 218-09-0628

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Velma Glary

6 (c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): August 8, 1899

8. AGE: Years	Months	Days	If less than one day
55 55	7	9	hr. min.

9. Birthplace: Balto, Md.
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business:

FATHER

12. Name: James Shook

13. Birthplace: Md.

MOTHER

14. Maiden Name: Minerva Webber

15. Birthplace: Md.

16 (a) Informant: Velma ~~Rennie~~ Shook

(b) Address: 3220 ~~US Marine Hospital~~ Belair Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 20 48 (month) (day) (year)

(c) Cemetery or crematory: Balto. National

Location: Frederick Rd

18 (a) Funeral director: Dippel Bros.

(b) Address: 3110 Belair Rd

19 (a) MAR 19 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17 1948, at 7:10P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 9 1948 to Mar. 17 1948, and that I last saw him alive on Mar. 17 1948.

Immediate cause of death	Duration
Cardiac dilatation and hypertrophy with congestive failure	28 yrs
Due to	
Due to	
Other Conditions: Multiple old infarcts of spleen and kidney (Include pregnancy within 3 months of death)	Unknown

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury:

23. Signature: John L. Wilson

John L. Wilson, Sr. Surgeon M. D.

Address: Clinical Director Date signed: 3/18/48

VS 150

X

61381

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 47c

Registered No. 61381

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4344 Parkside Dr.
(c) Hospital or institution: 26-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4344 Parkside Dr (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John G. Hall

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Clara

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) June 5 1889

8. AGE: Years 58 | Months 9 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Manager laundry

11. Industry or business Laundry

FATHER
12. Name Gottlieb Hall
13. Birthplace Balto

MOTHER
14. Maiden Name Mary Nörtney
15 Birthplace Balto

16 (a) Informant Clara Hall
(b) Address 4344 Parkside Dr

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 20 48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Rd.

18 (a) Funeral director Dippel Bros.
(b) Address 7110 Belair Rd

19 MAR 19 1948 (Date rec'd by registrar) (b) Huntington Hills Burial Park

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1948 at 1 55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1946 to March 18 1948 and that I last saw h alive on March 12 1948

Immediate cause of death: Bronchopneumonia Carcinoma, left

Due to

Due to

Other Conditions Rheumatism
Circulatory disorder disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
3 yrs.
30 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Adams G. Hall M. D.
Address 6732 Belair Rd Date signed March 18 1948

VS 150

061382
AB-91334

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

061382 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 1-1
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 67yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 817 S. Decker Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Delia Herrlein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Widowed

6 (b) Name of husband or wife John (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 3- 1872

8. AGE: Years	Months	Days	If less than one day
75	7	15	hr. min.

9. Birthplace Ireland
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name John O'Connor
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary K anavk-or-Kanovh
15 Birthplace I reland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (b) Date thereof 3 20 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL RD
18 (a) Funeral director DIPPEL BROS.
(b) Address 1810 ELDORADO ST.
19 (a) MAR 19 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18- 1948, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-29- 1944 to 3-18- 1948, and that I last saw her alive on 3-18- 1948.

Immediate cause of death	Duration
Bronchopneumonia, Bilat. chiefly at lower lobe,	? days
Due to organism undet.	
Arteriolarnephrosakrosis	? years
~~Due to~~ Arteriosclerotic Heart	
disease & cardiac hypertrophy	years
Other Conditions Parkinsonism, Gen'l	
osteoarthritis, Senile Psychosis	

(Include pregnancy within 3 months of death)
Date of operation 2-2-45
Major findings of operation: Fracture neck of left femur
of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 1/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 12-29-44 at ? M
(c) Where did injury occur? Rear- 817 S. Decker Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home Yard (Specify type of place) While at work? no
(e) Means of injury Slipped & fell in yard
23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp Date signed 3-18-48

VS 150

To be approved by the Medical Examiner
M. P. B. Babbs, by Thomas J. Mullen, M.D.

1883 J. J. Thomas
4600 York Road

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G61383

1. PLACE OF DEATH: 27-11
(a) Baltimore City, Maryland
(b) Street address 2101 Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4638 Kernwood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna M. Laur

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Frank Laur
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1-1869

8. AGE: Years	Months	Days	If less than one day
79	1	15	hr. min.

9. Birthplace Germany (Town, county and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Engel
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mr. Joseph G. Laur
(b) Address 4638 Kernwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) MAR 19 1948 (Date rec'd by registrar) (b) Lemuel Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1948, at 10:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/14 1948, to 3-16 1948, and that I last saw her alive on 3/16 1948.

Immediate cause of death: Pulmonary Edema — Duration: 12 hrs
Due to: Arteriosclerotic Cardio vascular disease — years
Due to: with fibrillation & decompensation
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Anthony J. Thomas M. D.
Address 4600 York Rd Date signed 3/17/48

VS 150

G61384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164c

Registered No. G61384

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: S. Balto. Gen'l. Hosp. W-V
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 673 W. Barrie St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB FIERSUK, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-03-4789

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11-1921

8. AGE: Years	Months	Days	If less than one day
26	8	5	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Handy Work

11. Industry or business

FATHER
12. Name Jacob Fiersuk.
13. Birthplace Russian

MOTHER
14. Maiden Name Constanzia ?
15. Birthplace Lithuanian

16 (a) Informant Mr. Jacob Fiersuk.
(b) Address 673 W. Barre St

17 (a) Burial (b) Date thereof Mar. 20-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Road

18 (a) Funeral director John A. Grefliancka Jr.
(b) Address 423 S. Paca St.

19 MAR 19 1948 (Signature) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1948, at 11:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-16-48 at P.M.
(b) Where did injury occur? 673 W. Barrie St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury Firearm

23. Signature Earl Kaye M.D.
Medical Examiner.
Date signed 3-17-48

VS 151

d:- # 5- Anchorage (U. S. Coast Guard)
1385 BALTIMORE CITY HEALTH DEPARTMENT (1st Commandery)
CERTIFICATE OF DEATH 173 Registered No. G61385

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 East Street
(c) Hospital or institution: City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dor.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Arlington (If outside city or town limits, write RURAL and give town)
(d) Street No. 4631 S. 36th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles W. (SCHUH) SHUE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Ruth Vogel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1918

8. AGE: Years 29 | Months 11 | Days 26 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date of [illegible] March 20-48 (month) (day) (year)

(c) Cemetery or crematory Dorf Meyer

Location Galesville, Virginia

18 (a) Funeral director Pratt & B. M. Watts

(b) Address Pratt & Tucker Sts

19 (a) MAR 19 1948 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-18-1948 at 7 P. M.

21. I certify that I took charge of the remains described above, held an Inspection of Body thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-24-48 at ? 26/6 M.
(b) Where did injury occur? Chesapeake Bay
(c) Did injury occur at home, on farm, industrial place, in public place? At Sea While at work? Yes (Give exact location)
(d) Means of injury Drowning

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 3/19/48

VS 151

9 1948

X

61386 HRBeK ✓ X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G61386

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Gilmor & Lombard St
(c) Hospital or institution:
Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Cecil
(c) City or town Hillside, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Frank Hrbek.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Frances

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4/8/1888

8. AGE: Years	Months	Days	If less than one day
59	11	10	hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)

10. Usual Occupation BAKER

11. Industry or business

FATHER
12. Name FRANK HRBEK
13. Birthplace Czechs.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace Czechs

16 (a) Informant FRANCES HRBEK
(b) Address Hillside, Md.

17 (a) Removal (b) Date thereof 3/19/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Washington D.C
Location

18 (a) Funeral director W. W. Chambers Co.
(b) Address Washington D. C.

19 (a) MAR 19 1948 (b) Washington, Md. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-18 1948, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15 1948 to 3-18 1948 and that I last saw h[illegible] alive on 3-18 1948

Immediate cause of death	Duration
Bronchial Cardiac failure	
Due to Bilateral bronchial pneumonia	
Due to	
Other Conditions arteriosclerosis, emphysema & edema	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard E. Krall M.D.
Address Wash. Hosp. Date signed 3-18-48

VS 159

X

G61387 ✓ G61387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1120 Riverside Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1120 Riverside Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Welsh Sr.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary M. McMahon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 24, 1887

8. AGE: Years 61 | Months 1 | Days 27 | If less than one day: hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business None

FATHER
12. Name Richard Welsh
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Catherine Eagan
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Mary M. Welsh
(b) Address 1120 Riverside Ave.

17 (a) Burial (b) Date thereof Mar 20 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore Md.

18 (a) Funeral director Flynn & Flynn
(b) Address 1476 Light St.

19 (a) (b)
(Date received by registrar) Registrar

MAR 19 1948

Huntington Woods, Mich.

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1948 at 11:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1948 to March 17 1948; and that I last saw him alive on March 16 1948.

Immediate cause of death: Myocardial Insufficiency — Duration:
Due to —
Due to
Other Conditions: Pulmonary Tuberculosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? —
(Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph G. Schuenck M.D.
Address 1337 S. Charles St. Date signed 3/19/48

93)

61388

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46E

Registered No. 661388

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1734 Tyrrell Hove
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1734 Tyrrell Hove (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H Ramsey

3 (b) If veteran, name war —
3 (c) Social Security Account No. 162-12-7034

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emma S

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 14 1885

8. AGE: Years 62 | Months 5 | Days 25 | If less than one day hr. min.

9. Birthplace Ga (Town, county, and state)

10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Emma S Ramsey
(b) Address 1734 Tyrrell Hove

17 (a) Burial, cremation, or removal Burial (b) Date thereof 3/20/48 (month) (day) (year)
(c) Cemetery or crematory Altoona
Location Altoona Pa

18 (a) Funeral director Thompson Funeral Home
(b) Address 2317 Ford Ave

19 MAR 20 1948 (Date rec'd by registrar) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1948, at 5 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 14, 1948, to Mar. 19, 1948, and that I last saw him alive on Mar. 18, 1948.

Immediate cause of death: Carcinoma of Sigmoid — Duration: 10 mos.

Due to ---- ----

Due to -------

Other Conditions ---------

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo W Montgomery MD
Address 404 E. 25th. St. Date signed 3/19/48.

VS 150

X

661389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 661389

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 W. Lexington St
(c) Hospital or institution: Home of Our Lady
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2102 Maryland Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Eugenia Boer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	widow

6 (b) Name of husband or wife Philips
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26-1873

8. AGE: Years	Months	Days	If less than one day
74	7	23	hr. min.

9. Birthplace Dorchester Co. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Hopkins
13. Birthplace Dorchester County, Md.

MOTHER
14. Maiden Name Henrietta Richardson
15. Birthplace Church Creek, Md.

16 (a) Informant Mrs. Ethel Junker
(b) Address 2102 Maryland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave. + Rose Sts.

18 (a) Funeral director Wm. Cook Sons
(b) Address 1217 St. Paul St.

19 (a) MAR 20 1948 (Date rec'd by registrar) (b) [illegible] Williams Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1948 at 3:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 10 1948 to Mar 19 1948 and that I last saw h[illegible] alive on Mar 19 1948

Immediate cause of death: Acute Cardiac Dilitation — Duration: 1 day
Due to: Cardio Vascular disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Glassman M. D.
Address 753 W. Lafayette Date signed Mar 20

correct age is especially important. Physicians: please write the cause of death plainly.

V S 150

061390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 061390

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W. Lexington St.
(c) Hospital or institution:
Aged Women's & Aged Men's Homes
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Sellar Shoemaker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Robert E. Shoemaker 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29th 1863

8. AGE: Years	Months	Days	If less than one day
84	9	29	21 hr. min.

9. Birthplace Salisbury N.C.
(Town, county and state)
10. Usual Occupation Inmate
11. Industry or business Home for Aged

FATHER
12. Name Alexander Sellar
13. Birthplace

MOTHER
14. Maiden Name Mary L. Chase
15. Birthplace

16 (a) Informant L. H. Read Supt.
(b) Address 1400 W. Lexington St.

17 (a) Burial (b) Date thereof 3/20/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) MAR 20 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18th 1948, at 6.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1947 to March 17 1948, and that I last saw her alive on March 17 1948.

Immediate cause of death	Duration
Myocardial Failure	
Due to Arteriosclerotic Myocarditis	
Due to	
Other Conditions Generalized arteriosclerosis, Cardio-vascular disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maitland Edmund Day M. D.
Address 4-E-33rd St. Balto 18 Date signed March 19 1948

correct age is especially important. Physicians, please write plainly.

V S 150

Huntington Williams, M.D.

X

661391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83 B

Registered No. 661391

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maria Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Cathedral + Mulberry Sts (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robider Dorothea B (Dorthea B Robider)

3 (b) If veteran, name war: Wid of
3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30. 1891

8. AGE: Years 56 | Months 5 | Days 19 | If less than one day hr. min.

9. Birthplace Savannah Ga (Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER 12. Name Henry G Robider
13. Birthplace Ga

MOTHER 14. Maiden Name Unknown
15. Birthplace Ga

16 (a) Informant Mrs Mary L Robider
(b) Address Next mo Apts, Cathedral St

17 (a) Savannah (Burial, cremation, or removal) (b) Date thereof 3/20/48 (month) (day) (year)

(c) Cemetery or crematory Savannah
Location Savannah Ga

18 (a) Funeral director Fallon & Cody
(b) Address 1319 Park Ave

19 (a) MAR 20 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 19 19 4t at 6 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 19 48 to Mar 19 19 48 and that I last saw h er alive on Mar 19 19 48.

Immediate cause of death: Cerebral thrombosis — Duration: 6 weeks

Due to

Due to

Other Conditions: Chronic bronchitis about 10 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harris D. L. Davis M. D.
Address Tenpas Hosp Date signed 3-19-48

VS 150

X

61392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 61392

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland and Rayner Ave.
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 Dys
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2715 Winchester St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN J. GRIFFITH

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 216-01-1054

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Minnie E. Griffith
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) June 29, 1900

8. AGE: Years	Months	Days	If less than one day
47	8	11	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business City Contracting Co.

FATHER
12. Name Harry V. Griffith
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Irene Weckert
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Minnie E. Griffith
(b) Address 2715 Winchester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (Date rec'd by registrar) MAR 20 1948 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 18, 1948 at 6 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-2- 1948 to 3-18 1948, and that I last saw h/M. alive on 3-18 1948.

Immediate cause of death	Duration
(1) PNEUMONIA,	
BILATERAL (2) UNDIAGNOSED	
CONDITION OF BRAIN, CAUS-	
~~Due to~~ ING PROGRESSIVE COMA	
+ PARALYSIS, PROBABLY IN-	
~~Due to~~ FLAMMATORY IN NATURE.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 3-13-48

Major findings of operation: THICKENED MENINGES, CEREBRAL EDEMA

of autopsy: SAME AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Goubmtolay M.D.
Address West Baltimore General Hosp. Date signed 3/20

VS 180

G1393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. G1393

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1618 W. North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life time

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 W. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertie Baum Scher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	white	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1901

8. AGE: Years	Months	Days	If less than one day
46	9	6	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name Wm Baum
13. Birthplace Balto Md

MOTHER
14. Maiden Name Jennie Katz
15. Birthplace Balto Md

16 (a) Informant Miss Shirley Setter
(b) Address 5517 Raynorville Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 21 48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location Balto City

18 (a) Funeral director Harold Goodman & Son
(b) Address 1907 Eutaw Place, Balto 17

19 (a) MAR 20 1948 (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 March 1948, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon Monoxide Poisoning

Due to Illuminating Gas

Other Conditions Mental Depression, Despondency
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-19-48 at ? P.M.
(b) Where did injury occur? 1618 W. North Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Illuminating gas

23. Signature Wm. B. Fannin M.D.
Medical Examiner.
Date signed 19 Mar. 1948

61394 EL-114321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH • 13B

Registered No. C61394

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha DeShields

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1925

8. AGE: Years	Months	Days	If less than one day
23	-	3	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Sewell Cox
13. Birthplace Md.

MOTHER
14. Maiden Name Mamie Stewart
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3-22-1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Chas. A. Hyland
(b) Address 163 Edmondson Ave.

19 MAR 20 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1948, at 11am M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 7 1947 to March 18 1948, and that I last saw h er alive on March 18 1948.

Immediate cause of death	Duration
Tuberculous, pulmonary, far-advanced, bilateral. (b) TB	
Due to aspiration	2 hrs
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation: Pleural effusion, bilat.; pericardial effusion

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee M. D.
Address Baltimore City Hosp. Date signed 3-19-48

VS 139

X

661395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 309

Registered No. 661395

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Street 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 Rutter Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mable Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alexander

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 13, 1904

8. AGE: Years 43 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace: Richmond, Va
(Town, county, and state)

10. Usual Occupation: Housemaid

11. Industry or business

FATHER
12. Name: Phillip Cheatham
13. Birthplace: Va

MOTHER
14. Maiden Name: Viola ? ? ?
15. Birthplace: Va

16 (a) Informant: Alexander Brown
(b) Address: 1512 Rutter St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3-22-1948 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn
Location: Baltimore, Md.

18 (a) Funeral director: Mrs. Laura M. Stanback
(b) Address: 1681 Druid Hill Ave.

19 (a) MAR 20 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-19- 1948 at 10 A. M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquest thereof and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to HER death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Rheumatic C.V. disease

Due to

Other Conditions: Syphylis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Nature of injury

23. Signature: C. R. Sulzbacher M.D.
Medical Examiner.
Date signed 3-19-48

95B

61396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

✓ G61396 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1232 N. Lanvale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1232 N. Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Ida Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: Female | 5 Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Robert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1899

8. AGE: Years 48 | Months 5 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore Co. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name James A. Adams

13. Birthplace New Jersey

MOTHER 14. Maiden Name Lucie Price

15. Birthplace Virginia

16 (a) Informant Miss Celestine Brown

(b) Address 1232 N. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-1948 (month) (day) (year)

(c) Cemetery or crematory Arbutus

Location Balto. Co. Md.

18 (a) Funeral director Mrs. Eug. H. Holland

(b) Address 1631 Druid Hill Ave

19 (a) MAR 20 1948 (Date rec'd by registrar) (b) Lurtington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-15 1948 at 11:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14 1948 to 3-15 1948 and that I last saw h[illegible] alive on 3-15 1948.

Immediate cause of death	Duration
Acute Dilatation of Heart	1d.
Due to Cerebral Apoplexy	1d.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. A. Berry M. D.

Address 1420 E. Chase Date signed 3-19-48

VS 150

X

61397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 193

Registered No. 61397

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mt. Royal Tunnel B. & O. R. R.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 2719. 13 St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James JONES

3 (b) If veteran, name war W.W-II

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/1/1923

8. AGE:	Years	Months	Days	If less than one day
	24	5	17	hr. min.

9. Birthplace Clairton, Penna (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business U. S. Govt

FATHER 12. Name	Lehigh Jones
13. Birthplace	N.C.
MOTHER 14. Maiden Name	Mary Pitt
15. Birthplace	N.C.

16 (a) Informant Lehigh Jones
(b) Address 449 Park Ave. Clairton

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/48 (month) (day) (year)

(c) Cemetery or crematory Clairton, Penna
Location

18 (a) Funeral director Chas R. Law
(b) Address 807 Madison Ave

19 (a) MAR 20 1948 Huntington Williams Funeral Home
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1948, at 10:55 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Electrocution

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 11/2 P.
(a) Date of injury March 18 48 10:55 M.
(b) Where did injury occur? MT. Royal Tunnel
(c) Did injury occur at home, on farm, industrial place, in public place? R.R. Property While at work? No
(d) Means of injury High Voltage

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 3/18/48

X

VS 151

Correct age is especially important

1398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 061398

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17hr. 40min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Washburn Avenue
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME John Swanke, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-6036

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 188[illegible]

8. AGE: Years 66 | Months 7 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Machine Shop

11. Industry or business Balto. Marine Repair Shop

FATHER
12. Name William Swanke
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Margaret Swanke
(b) Address 901 Washburn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 22/48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Pitcher Highway

18 (a) Funeral director Walter T. Schweinsburg
(b) Address 1216 W. Cross st

19 (a) MAR 20 1948 (Date rec'd by registrar) (b) Interment or Removal

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18, 1948, at 6:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17 1948 to 3/18/ 1948, and that I last saw him alive on 3/18/ 1948.

Immediate cause of death Acute pulmonary edema

Due to Pulmonary embolism

Due to Arterio sclerotic C.V.D.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address St Joseph's Hosp. Date signed 3/19/48

correct age is especially important. Physicians please

VS 150

61399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. 61399

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4211 Nicholas Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4211 Nicholas Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Mary Katherine Seibold

3 (b) If veteran, name war None | 3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife John W. Seibold
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jul 22, 1901

8. AGE: Years	Months	Days	If less than one day
46	7	26	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Wm. Beger
13. Birthplace Germany

MOTHER
14. Maiden Name Eva Beger
15. Birthplace Germany

16 (a) Informant Mr. John W. Seibold
(b) Address 4211 Nicholas Ave.

17 (a) Burial (b) Date thereof 3/22/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Wm. T. Tickner & Sons
(b) Address Baltimore Md.

19 Mar 20 1948 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/18/48 19.., at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from November 1946, to March 18 1948, and that I last saw h[illegible] alive on March 11 1948.

Immediate cause of death	Duration
Acute Dilatation of Heart	0
Due to Hypertension	about 1 year.
Other Conditions Nonsyphilitic	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Isaac G. Imes M. D.
Address 516 Eutaw St. Date signed 3-19-48

VS 150

X

61400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 61400

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 209 Druid Hill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John T. Fox

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Widower

6 (b) Name of husband or wife Marie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1887

8. AGE: Years	Months	Days	If less than one day
60	2	22	hr. min.

9. Birthplace Caroline County Va.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Lucille Deaney
(b) Address 2109 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 20 48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Balto. County

18 (a) Funeral director Mrs Roth A. Elliott & Dy
(b) Address 1129 N. Carlton St

19 (a) MAR 20 1948 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16- 1948, at 6:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/14 1948 to 3/19 1948, and that I last saw h alive on 3/14 1948.

Immediate cause of death Cardio-Vascular Renal Disease

Due to Uremia Coma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 1 year 2 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. T. Jackson

Address Cor Mallory & Eutaw Date signed 3/19/48

VS 153

61401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

85

Registered No. 61401

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 404 N. Durham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Percy Washington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years	Months	Days	If less than one day
37			hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Gertrude Washington
13. Birthplace Wash D.C.

MOTHER
14. Maiden Name Leggon Washington
15. Birthplace Va.

16 (a) Informant Gertrude Washington
(b) Address 404 N. Durham St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 20/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A. A. County

18 (a) Funeral director Mrs Pott & Elliott
(b) Address 1129 N. Carrine St

19 (Date rec'd by registrar) MAR 20 1948 Washington Funeral Home

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-18 1948, at 9:45 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Embolism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royster M.D.
Medical Examiner.
Date signed 3-18-48

VS 181

061402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓

Registered No. 061402

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 737 N. Central Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Odessa Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed or divorced. W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-27-09

8. AGE: Years 38 | Months 4 | Days 21 | If less than one day hr. min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Easton Plunkett
13. Birthplace N.C.

MOTHER
14. Maiden Name Dora Little
15. Birthplace N.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem,
Location Brooklyn, Md

18 (a) Funeral director Elroy H Wilson
(b) Address 1000 Edmondson ave

19 (a) MAR 20 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-17- 1948 at 4:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4- 1948 to 3-17- 1948 and that I last saw h[illegible] alive on 3-17- 1948.

Immediate cause of death Resp Ceased — Duration

Due to Uremia

Due to HCVD

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. Hussey M. D.

Address JHH Date signed 3-18-48

correct age is especially important

VS 150

X

61403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52a

Registered No. 61403

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1061 Myrtle Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Humphery Woody

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Robert Woodie
13. Birthplace Va

MOTHER
14. Maiden Name William Robinson
15. Birthplace Va

16 (a) Informant Humphery Woodie Jr.
(b) Address 1034 W Franklin

17 (a) Burial (b) Date thereof May 21 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Brooklyn Md.

18 (a) Funeral director Edgar A Wilson
(b) Address 1000 Pleasant

19 MAR 20 1948 (b) Lexington Mkt Registrar
(Date rec'd by registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16 1948 at 3:25 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypernephroma of right kidney with metastases to lymph-nodes and spine

Due to

Other Conditions Syphilitic aortitis. Myocardial hypertrophy and dilatation.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G Merrill M.D.
Medical Examiner.
Date signed 3-18-48

Correct age is especially important

1404 BALTIMORE CITY HEALTH DEPARTMENT G61404

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5915 York Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5915 York Road
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John Malac

(b) If veteran, name war | (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife (nee Koutny): Katherine Malac

6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) June 27, 1890 1870

8. AGE: Years 78 | Months 1 | Days 19 | If less than one day: 23 hr. — min.

9. Birthplace Czecho-Slovakia (Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER 12. Name Joseph Malac

13. Birthplace Czecho-Slovakia

MOTHER 14. Maiden Name Anna Kosova

15. Birthplace Czecho-Slovakia

16 (a) Informant Daughter

(b) Address Same address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/48 (month) (day) (year)

(c) Cemetery or ~~Crematory~~ Moreland
Location 5806 Harford Rd. Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.

(b) Address 2601-3-5 E. Madison Street

19 (a) MAR 20 1948 (Date received by registrar) (b) Huntington Hitt, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-18 1948, to 3-19 1948, and that I last saw him alive on 3-19 1948.

	Duration
Immediate cause of death Acute Dilatation of Heart	
Due to Chronic Myocarditis	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M Malac M. D.

Address 6014 York Road Date signed 3-19-48.

VS 3

1405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 661405

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 814 N. Montford Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 814 N. Montford Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KAROLINA DUBAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Albert Duban

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1863

8. AGE: Years 84 | Months 9 | Days 13 | If less than one day hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Melichar
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15 Birthplace unknown

16 (a) Informant August Duban - son
(b) Address 814 N. Montford Ave.

17 (a) Burial (b) Date thereof 3/20/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 26013-5 E. Madison Street

19 (a) MAR 20 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1948, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to March 17 1948, and that I last saw her alive on March 17 1948

Immediate cause of death: Coronary Thrombosis — Duration 3/17/48

Due to: Arteriosclerosis — 1/1/45

Due to: Arteriosclerosis — 1940

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Ryan M.D.

Address 801 N. Eutaw St. Date signed 3/19/48

VS 180

C61406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. C61406

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2727 Eastern Avenue
(c) Hospital or institution: None
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2727 Eastern Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M. Durkin

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	?	Female	White	Widowed

6 (b) Name of husband or wife Thomas H. Durkin
6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) 5-29-1877

8. AGE: Years	Months	Days	If less than one day
70	9	18	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name James Donnelly
13. Birthplace Baltimore

MOTHER
14. Maiden Name Anna R. Desable
15. Birthplace Baltimore

16 (a) Informant Mary Stevens
(b) Address 2727 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 1901 Eastern Avenue

19 MAR 20 1948 (Date rec'd by registrar) Washington Boulevard Baltimore Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17, 1948, at 11 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to March 17 1948.
and that I last saw her alive on 3/17 1948.

Immediate cause of death	Duration
Cerebral hemorrhage	8 weeks
Due to Hypertension	
Due to Cardio-Renal Vascular Disease	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 2128 N. Ponca St. Date signed 3/18/48

VS 150

Correct age is especially important

G61407

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1948

G61407 Registered No. 1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3408 Edmondson Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3408 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George F. Weikert

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W.	Married

6 (b) Name of husband or wife Maud Starlings
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1879.

8. AGE: Years	Months	Days	If less than one day
68	9	24	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Draftsman
11. Industry or business National Enamel & Stamp

FATHER
12. Name Frank Weikert
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia Seebo
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Maud Weikert,
(b) Address 3408 Edmondson Ave.

17 (a) Burial (b) Date thereof 3/22/48.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry A. Kitzke
(b) Address 4101 Edmondson Ave.

Mar 20 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18/48. 19 at 3 22/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1948 to 3/18 1948 and that I last saw h[illegible] alive on 3/18 1948

Immediate cause of death Coronary Thrombosis — Duration 3/18/48

Due to Arteriosclerotic Cardiovascular Disease — Duration 5+ yrs

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward E. Rosch
Address 3629 Edmondson Ave. Date signed 3/18/48 M. D.

PLEASE WRITE PLAINLY. With pencil. Use ink. Do not abbreviate. Be correct. Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Edw. E. Rosch X

G61408

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 49a

G61408 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden ave & Madison St
(c) Hospital or institution:
Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2716 St Paul St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Spier (MRS. MARY ELIZABETH SPIER)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Andrew A. Spier, MD.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12, 1921

8. AGE: Years	Months	Days	If less than one day
26	6	8	hr. min.

9. Birthplace Wilmington, Delaware
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Howard L. Exler
13. Birthplace Wheeling, W. Va.

MOTHER
14. Maiden Name Mary B. McDonald
15. Birthplace Buckhannon, W. Va.

16 (a) Informant Dr. A. Allan Spier
(b) Address MD. Genl Hosp.

17 (a) Removal (b) Date thereof 3/20/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rosehill
Location Cumberland, Md.

18 (a) Funeral director Wm. J. Tichner & Sons
(b) Address Balto. Md.

19 (a) (b) Washington Williams M.D.
Date rec'd by registrar Registrar
MAR 21 1948

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1948, at 7:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1948 to March 20 1948 and that I last saw her alive on March 20 1948

Immediate cause of death CARDIAC FAILURE — Duration

Due to GENERALIZED CARCINOMATOSIS

Due to EITHER OVARIAN OR GASTROINTESTINAL IN

Other Conditions ARTERIOSCLEROSIS

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. L. Monaugh. M. D.
Address MD. Gen. Hosp. Date signed 3-20-48

correct age is especially important.

X

C61409

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

C61409
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 530 S Longwood Road
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME August C. Knust

3 (b) If veteran, name war None
3 (c) Social Security Account No. 219-20-7095

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Marie Justine Knust
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1875

8. AGE: Years 72 | Months 8 | Days 26 | If less than one day ..... hr. ..... min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Retired
11. Industry or business —

FATHER
12. Name Carl Knust
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Wengel
15. Birthplace Germany

16 (a) Informant Marie Justine Knust
(b) Address 530 S. Longwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave.

19 MAR 21 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 19 48 at 3:45 M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature W. A. Gelbach M.D.
Medical Examiner.
Date signed 3/18/48

correct age is especially important

VS 181

X

661410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

661410 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2505 Brookfield Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 / 20 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2505 Brookfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Esther Greenbaum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Isaac
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1880

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace London England
(Town, county, and state)

10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name David Frush
13. Birthplace London

MOTHER
14. Maiden Name Dora ?
15. Birthplace London

16 (a) Informant Miss Ann Greenbaum
(b) Address 2505 Brookfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 21, 1948 (month) (day) (year)
(c) Cemetery or crematory Aitz Chaim Con g Cem
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

(a) MAR 21 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 4.10

20. DATE OF DEATH March 19 1948, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to March 19, 1948, and that I last saw h[illegible] alive on March 18, 1948.

Immediate cause of death Acute cardiac dilatation — Duration
Due to Hypertension
Due to Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sidney L. Levy M. D.
Address 2[illegible] Eastern Pkwy Date signed 3/19/48

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and correct age is especially important.

V S 150

Huntington Williams, M.D.

661411

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. 661411

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Gen. Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 46 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2406 Baker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Clara Lubchansky
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	Widow

6 (b) Name of husband or wife Jacob W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Russia. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

MOTHER | FATHER
12. Name Mone
13. Birthplace Russia
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant ZEB LEVY
(b) Address 2406 BAKER ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-21-48 (month) (day) (year)
(c) Cemetery or crematory BETH TFILOH
Location WINDSOR MILL RD
18 (a) Funeral director JACK LEWIS INC
(b) Address 2100 EUTAW PLACE
19 (a) (Date rec'd by Registrar) (b) Signature of Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1948, at 4:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2 Feb 1948 to 19 March 1948.
and that I last saw her alive on 19 March 1948.

Immediate cause of death	Duration
Peritonitis - vascular collapse	
Due to Post amputation Right leg - gas gangrene thigh	
Due to Arteriosclerosis	
Other Conditions Gangrene left leg A & CVD	

(Include pregnancy within 3 months of death)
Date of operation 3-4-48
Major findings of operation: Amputation Gangrene - Arteriosclerosis
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Strateher M. D.
Address W B G H. Date signed March 19 1948

150

G61412

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 194a

G61412 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 812 WHITELOCK ST
(c) Hospital or institution: 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 812 WHITELOCK ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB HARRIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife TILLIE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 64 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace ROUMANIA (Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business

FATHER 12. Name JOSEPH HARRIS

13. Birthplace ROUMANIA

MOTHER 14. Maiden Name LIBBY

15 Birthplace ROUMANIA

16 (a) Informant S. HERBERT HARRIS

(b) Address 812 WHITELOCK ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-21-48 (month) (day) (year)

(c) Cemetery or crematory HEBREW YOUNG MEN

Location WINDSOR MILL MD

18 (a) Funeral director Jack Lewis Inc

(b) Address 2100 Eastern Ave Washington Baltimore, Md.

18 (a) MAR 21 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20-1948, at 2:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-10 1948 to 3-20 1948, and that I last saw him alive on 3-18 1948

Immediate cause of death: Coronary thrombosis / Hypertension — Duration: Sudden

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Edmund Cohen M. D.

Address 3400 Fulton Ave Date signed 3/20/48

correct age is especially important. Physician, please

VS 159

X

G61413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G61413

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or Institution: Lewndale
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Lewndale (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Goldstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Jannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years	Months	Days	If less than one day
84			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Maurice Goldstein
(b) Address 277 N Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 2 [illegible] Place

19 (a) 21 1948 (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1948, at 7 20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 5 1948 to March 19 1948, and that I last saw h[illegible] alive on March 19 1948

Immediate cause of death	Duration
Pulmonary edema	
Due to Coronary insufficiency	
Due to	
Other Conditions Cerebral Arteriosclerosis, Hypertensive, Pneumonia ? (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jeanne J. Blumberg M. D.
Address Lewndale Lane Date signed 3/19/48

PLEASE WRITE PLAINLY. Physicians: please write the cause of death clearly and report correct age is especially important.

VS 150

661414

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

661414 467 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3700 Labyrinth Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3700 Labyrinth Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Trentraub

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name unknown
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Rose Trentraub
(b) Address 3700 Labyrinth Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20-1948, at 7:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/16/1946 to 3/20/1948, and that I last saw him alive on 3/20/1948.

Immediate cause of death Carcinomatosis with generalized metastasis — Duration: 1 year

Due to Carcinoma of rectum — Duration: 2 years

Due to — Duration:

Other Conditions — Duration:

(Include pregnancy within 3 months of death)

Date of operation 3/16/1946

Major findings of operation: Carcinoma of rectum

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Huntington Williams M.D.
Address 2310 Eutaw Pl Date signed 3/21/1948

correct age is supplied by informant

VS 150

G61415

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G61415 131 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 839 Lexington Hall Street (Greyn v Redwood)
(c) Hospital or institution: University Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 839 Lexington Hall Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hilda Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/9/16

8. AGE: Years 32 | Months 2 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation W.W

11. Industry or business

FATHER
12. Name Andrew Lisby
13. Birthplace Va

MOTHER
14. Maiden Name Getrude Forbes
15. Birthplace Balto Md

16 (a) Informant Getrude Lisby
(b) Address 611 S Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md

18 (a) Funeral director Isaac L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) MAR 21 1948 (Date rec'd by registrar) (b) Washington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17/48 19 , at 2:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/15/48 19 , to 3/17/48 19 , and that I last saw her alive on 3/17/48 19 .

Immediate cause of death Pulmonary edema — Duration

Due to Chronic renal disease

Due to

Other Conditions Uremia Pericarditis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Univ. Hosp. Date signed 3/17/48

VS 153

G61416 — BALTIMORE CITY HEALTH DEPARTMENT — G61416 Registered No.

CERTIFICATE OF DEATH

107

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and report correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2826 Dillon St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2826 Dillon st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Stradzinski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: widow
6 (b) Name of husband or wife: John
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 18 1873
8. AGE: Years 75 | Months 2 | Days - | If less than one day hr. min.
9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER / FATHER
12. Name Michael Rosinski
13. Birthplace Poland
14. Maiden Name Antonina Tarnowska
15. Birthplace Poland

16 (a) Informant Frances Wierzbowska
(b) Address 2826 Dillon St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 (month) 22 (day) 48 (year)
(c) Cemetery or crematory St. Stanislaus Rom
Location Dundalk Ave
18 (a) Funeral director Stephen J. Fratkowski
(b) Address 1000 S. Kenwood Ave
19 (a) 1948 (Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1948, at 7 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 8 1948, to March 18 1948, and that I last saw h[illegible] alive on March 18 1948.

Immediate cause of death: dc Bronch. Pneumonia — Duration: 10 days
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. A. Rosenblatt M. D.
Address 3018 O'Donnell St. Date signed 3-19-48

X

G61417

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93E

G61417 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1615 Division St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 4
(e) Length of stay in Baltimore (yrs., mos., or days) 42 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 1615 Division St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** (Mary) Mamie Neal Holt

3 (b) If veteran, name war | 3 (c) Social Security Account No. —

4 Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Albert Holt | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1869

8. AGE: Years 78 | Months 11 | Days 28 | If less than one day hr. min.

9. Birthplace Towson, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James H. Smith
13. Birthplace Towson, Md.

MOTHER
14. Maiden Name Adelaide Taylor
15. Birthplace Balto. Md.

16 (a) Informant Cora L. Lee
(b) Address 1512 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-1948 (month) (day) (year)
(c) Cemetery or crematory Pleasant Hill
Location Towson, Md.

18 (a) Funeral director Mrs. Lucie M. Hollan
(b) Address 1601 Druid Hill Ave.

19 (a) MAR 21 1948 (Date rec'd by registrar) (b) Huntington, W. Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-18-1948, at 4 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-5-1948 to 3-18-1948, and that I last saw h-- alive on 3-18-1948

Immediate cause of death Coronary Sclerosis — Duration 18 mos

Due to Myocarditis — Duration 3 years

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. L. Camper M. D.
Address 639 N. Carey St Date signed 3-21-48

VS 190

PLEASE WRITE PLAINLY. Fill in all blanks by typewriter or with pen and ink. Be sure to correct age is especially important. Physicians: please write the cause of death clearly and

G61418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1276

G61418 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 48 days
(e) Length of stay in Baltimore (yrs., mos., or days) 48 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto.
(c) City or town Baldwin
(If outside city or town limits, write RURAL and give town)
(d) Street No. none
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mr. Walter Peterson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Mrs. Stella Peterson
6 (c) If alive, give age 2 years

7. Birth date of deceased (mo., day, yr.) 13 December 1880

8. AGE: Years	Months	Days	If less than one day
67	3	8	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation merchant
11. Industry or business —

FATHER
12. Name Radford Peterson
13. Birthplace Virginia

MOTHER
14. Maiden Name Annie Fisher
15. Birthplace Virginia

16 (a) Informant Patient himself.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 23-48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore Co. Md.

18 (a) Funeral director Chas. J. Todd
(b) Address Reisterstown, Md.

19 (a) (Date rec'd by registrar) MAR 21 1948 (Huntington Williams, M.D.) Registrar

S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 March 1948 at 7 35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2 Feb. 1948 to 21 March 1948 and that I last saw h[im] alive on 20 March 1948

Immediate cause of death	Duration
Hypostatic (Bronchial) pneumonia	20 hrs.
Due to Intestinal obstruction	2 days
Due to Post operative complication	Est.
Baldwin cholecystectomy.	
Due to	
Other Conditions Arteriosclerotic myocardial disease	

(Include pregnancy within 3 months of death)

Date of operation 9 March 1948
Major findings of operation Chronic gall bladder disease.
If autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G. J. Fisher M. D.
Address Church Home Date signed 3-21-48

correct age is especially important. Physicians, please write

X

CH. 661419 117972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓12

Registered No. 661419

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals. 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 149 Hamburg ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jerry Lennon ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April -16- 1926

8. AGE: Years	Months	Days	If less than one day
21	10	24	hr. min.

9. Birthplace S.C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jerry Lennon
13. Birthplace S.C.

MOTHER
14. Maiden Name Luelle Gardner
15. Birthplace S.C.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead & Co.
(b) Address 918 Druid Hill Ave. Undertaking for Wilmington, Del.

19 (a) (Date rec'd by registrar) Registrar

21 1948

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 3- 10 - 1948, at 1.30AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3 - 7 - 1948 to 3 - 10 - 1948, and that I last saw h im alive on 3 - 10 - 1948.

	Duration
Immediate cause of death: Cerebratory Collapse	1 day
Due to: Tetanus	7 Days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. C. Robinson Jr. M. D.
Address Balt. City Hos. Date signed 3/18/48

X

Correct age is especially important. Physicians: please write the causes of death clearly.

G61420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G61420

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3923 Foster Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT W. HOCK

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/21/33.

8. AGE: Years 14 | Months 2 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, County, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Frank Hock
13. Birthplace Baltimore Co. Md

MOTHER
14. Maiden Name Margaret Mrs. Catherine
15. Birthplace Baltimore Md.

16 (a) Informant Frank Hock (Father)
(b) Address 3923 Foster Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-48. (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location 4701 Germany Hill Rd.

18 (a) Funeral director Charles L. Zeiler
(b) Address 901 S. Conkling St.

19 (a) (Date received by registrar) (b) Huntington Williams, Registrar

MAR 21 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1948 at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 13 1948 to March 18 1948, and that I last saw h/ he alive on March 18 1948.

Immediate cause of death Acute Glomerulo Nephritis with Carcinoma Fracture of Uremia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank E. Farrow

Address Mercy Hospital Date signed 3/18/48

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G61421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 97

Registered No. G61421

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 202 N. Chapel St
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 202 N. Chapel St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rudolph M. Rieber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife Mary.
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Sept 29 1873

8. AGE: Years	Months	Days	If less than one day
74	5	19	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Rieber
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Busse
15. Birthplace Germany

16 (a) Informant Mrs. Mary Rieber
(b) Address 202 N. Chapel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof MAR. 22, 48 (month) (day) (year)
(c) Cemetery or crematory Emmanuel Cem
Location Gunpowder Lane

18 (a) Funeral director L. HEEMANN & SON
(b) Address 6067 Harford Rd.

19 (a) [illegible] (b) [illegible]
Date received by registrar [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 18 1948 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 15 1948 to Mar 18 1948, and that I last saw h[illegible] alive on Mar 17 48.

Immediate cause of death	Duration
(a) Coronary Thrombosis	
Due to (b) Arteriosclerosis	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2936 E. 33rd Date signed 3-20-48

PLEASE WRITE PLAINLY with pencil or pen. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

VS 150

G61422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 937

Registered No. G61422

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1936 Lanvetta Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County N.Y.
(c) City or town New York City.
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie Hightower

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace Edgefield S C
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name James Murray
13. Birthplace S C.

MOTHER
14. Maiden Name Millie Garrett
15. Birthplace S C

16 (a) Informant Julia Cage
(b) Address 1936 Lanvetta ave

17 (a) (Burial, cremation, or removal) (b) Date thereof 3-21-48 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Flushing, N.Y.

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna ave

MAR 22 1948 (Date rec'd by registrar) Washington, D.C. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1948, at 3:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 14 1948 to Mar 18 1948 and that I last saw h[illegible] alive on Mar 18 1948

Immediate cause of death	Duration
Myocardial Degeneration	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Franklin Phillips M.D.
Address 543 Penna Ave Date signed 3/21/48

V S 150

T

G61423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 937

G61423 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Harford Road
(c) Hospital or institution:
Harford Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
City or town Baltimore, Md. Street
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 E. 31st. Street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta Lawrence

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife George C. Lawrence
6 (c) If alive, give age (D) years

7. Birth date of deceased (mo., day, yr.) July 16th., 1862

8. AGE: Years 85 | Months 8 | Days 4 | If less than one day ########## min.

9. Birthplace Port Deposit, Maryland
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Henry Norick
13. Birthplace Wales

MOTHER
14. Maiden Name Rachael Lawrence
15. Birthplace Maryland

16 (a) Informant George M. Lawrence (Son)
(b) Address 1624 E. 31st Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location 1700 Greenmount Avenue, Balto. Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) Filed [illegible] (b) [illegible] (Registrar)
Huntington Ave Balto Md

V S 150

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20th., 1948, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 17-Nov 1947, to 20-Mar 1948, and that I last saw her alive on 19-Mar 1948.

Immediate cause of death — Duration
Coronary Thrombosis — 2 days
Due to
Arteriosclerotic Cardio — Nov-47
Due to Vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. W. Edmunds M. D.
Address 2746 The Alameda Date signed 20 Mar. 48

X

G61424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G61424 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 600 S Chapelgate Lane

(c) Hospital or institution: Emerest Sanatorium

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Prince George

(c) City or town Brandywine (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ira Grant Coley

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anne G

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 27 1867

8. AGE: Years 81 | Months 2 1 | Days 4 26 | If less than one day hr. min.

9. Birthplace Elmira N Y (Town, county, and state)

10. Usual Occupation Machinist Retired

11. Industry or business

FATHER 12. Name Samuel Coley

FATHER 13. Birthplace Unknown

MOTHER 14. Maiden Name —

MOTHER 15. Birthplace

16 (a) Informant Paul G Coley (Son)

16 (b) Address Brandywine Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/48 (month) (day) (year)

17 (c) Cemetery or crematory Lead Hill Location Suitland Rd SE Washington D C

18 (a) Funeral director H H Thompson

18 (b) Address 1864 Chas St Washington D C

19 MAR 22 1948 (Date rec'd by Registrar) (b) Registrar Huntington Williams M D

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1948 at 9 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 16 MAR 1948 to 21 Mar 1948 and that I last saw h~~im~~ alive on 21 Mar 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Myocardial insufficiency (mitral + aortic)	
Due to Arteriosclerosis and hypertensive Cardiovascular disease with	
~~Other Conditions~~ myocardial degeneration	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Emil N. Henning Jr M. D.

Address 4580 Edmondson Ave Date signed 21 Mar 48

PLEASE WRITE PLAINLY, with ink. Make no erasures. Be sure to answer all questions. Physicians: please write the causes of death clearly and legibly. Give correct age in especially important.

VS 150

61425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

Registered No. 661425

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20-8
(c) Hospital or institution: FRANKLIN Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1418 S. Augusta Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph C. Atkinson

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-0104

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Jane Rebecca -
(c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) May 10-1912

8. AGE: Years	Months	Days	If less than one day
35	10	10	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business

FATHER
12. Name Wm. Aloysius Atkinson
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Margaret Grindell
15. Birthplace

16 (a) Informant Wife
(b) Address 418 S. Augusta Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 29-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md

18 (a) Funeral director Thomas F. Kenny Inc
(b) Address Hollins & Fulmer Sts

19 (a) MAR 22 1948 (Date rec'd by registrar) (b) Flewellen for Wm.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20-1948 at 3:20 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary edema due to fractured skull with intracranial hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-20-48 12:15 A. M.
(b) Where did injury occur? Balto. & Stricker St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Blunt force

23. Signature [signature] M.D. Medical Examiner.
Date signed 3/20/48

correct age is obviously impossible. If unknown, state approximate

VS 151

426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G61426
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5600 Green Spring Ave.
(c) Hospital or institution: 27-15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5600 Green Spring Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JEROME SLOMAN.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Fortuna E. Sloman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5. 1889.

8. AGE: Years	Months	Days	If less than one day
58	6	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Attorney.
11. Industry or business

FATHER
12. Name Harry Sloman.
13. Birthplace Philadelphia, Pa.

MOTHER
14. Maiden Name Bettie Werner.
15. Birthplace Baltimore. Md.

16 (a) Informant Mrs. Fortuna Sloman.
(b) Address 5600 Green Spring Ave.

17 (a) Burial (b) Date thereof 3/22/48.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom
Location Baltimore, Md.

18 (a) Funeral director Harris Levin & Son
(b) Address 1902 Eutaw Place.

19 MAR 22 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20th. 1948, at A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/27 1947 to 3/20 1948. and that I last saw h(im) alive on 3/20 1948.

Immediate cause of death Coronary Thrombosis — Duration 11/27/47

Due to Coronary Sclerosis — Several years

Due to

Other Conditions Diabetes — 5 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. B. Wagner, M.D.
Address Esplanade Apts. Date signed 3/20/48

PLEASE WRITE PLAINLY, with ink. Use no abbreviations. Be sure to answer all questions. Please see that your entries are correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Errors & Omissions 94a

61427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G61327

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St
(c) Hospital or institution: Union Memorial Hospital 13-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 702 West Univ. Pkwy, #10 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ada W. Lenderking

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, (widowed) or divorced.
F	W	

6 (b) Name of husband or wife ~~[illegible]~~
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/18/80

8. AGE: Years	Months	Days	If less than one day
67	5	3	hr. min.

9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Haerich
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. L. Clark
(b) Address 702 W University Pkwy
17. Burial (Burial, cremation, or removal) (b) Date thereof 3/24/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Wm. Lyon Mc
18 (a) Funeral director Wilson & Son
(b) Address 214 E. Lond St.
19 MAR 22 1948 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21/48 19..., at 3:45 P.M
21. I certify that death occurred on the date above stated; that I attended deceased from 3/20 1948, to 3/21 1948, and that I last saw her alive on 3/21 1948.

Immediate cause of death	Duration
Congestive heart failure & pulmonary edema	
Due to Recent anterior myocardial infarction	
Due to Hypertensive arteriosclerotic heart disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature B. Clark Bibel M.D.
Address Union Memorial Hosp. Date signed 3/21/48

VS 150

X

Please write the cause of death clearly. Physicians: please write the cause of death clearly. correct age is especially important.

61428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G61428 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 6-2
(b) Street address
(c) Hospital or institution: West Balt Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 216 N Milton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT MISTER

3 (b) If veteran, name war

3 (c) Social Security Account No 213-10-0159

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 6, 1871

8. AGE: Years 76 | Months 7 | Days 16 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Carpenter Retired

11. Industry or business

MOTHER / FATHER

12. Name Henry Master

13. Birthplace Md

14. Maiden Name Sarah Workman

15. Birthplace Md

16 (a) Informant Florence Lowenthal

(b) Address 216 N Milton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/48 (month) (day) (year)

(c) Cemetery or crematory Edgemont M.E.

Location Edgemont Md

18 (a) Funeral director Pulhamus Co Inc

(b) Address 1214 E Lond St

19 (a) MAR 22 1948 (Date rec'd by registrar) (b) Interring for Williamson Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1948, at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-18 1948 to 3-21 1948, and that I last saw h~~im~~ alive on 3-21 1948.

Immediate cause of death PULMONARY EDEMA — Duration

Due to HYPERTENSIVE-ARTERIOSCLERO-TIC CARDIOVASCULAR DISEASE

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gilbert Rubenstein M.D.
Address West Baltimore General Hospital Date signed 3/24/48

Correct age is especially important. Physicians: please write the cause of death carefully and legibly.

G61429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G61429

1. PLACE OF DEATH: 1-2

(a) Baltimore City, Maryland

(b) Street address Belleau & Belvedere Aves

(c) Hospital or institution: Edgewood Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Days

(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 534 N Luzerne Ave (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME CATHERINE KASTNER

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Robert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 8. 1862

8. AGE: Years 65 | Months 3 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Michael Huron

13. Birthplace Germany

MOTHER 14. Maiden Name Henrietta Stengler

15. Birthplace Germany

16 (a) Informant Robert E Kastner

(b) Address 2913 Overland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/48 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Baltimore County Md

18 (a) Funeral director Wilhoyte & Son

(b) Address 2348 St Paul St

19 (a) MAR 22 1948 (Date rec'd by registrar) (b) Huntington Wilhoyte M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/20/48 1948, at 5:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1948, to March 20 1948, and that I last saw her alive on 3/20 1948.

Immediate cause of death Cerebral Hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

Duration 3/20/48 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence —

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury —

23. Signature C W Kaufman M.D.

Address 4331 Hayward Rd Date signed 3/20/48

correct age is especially important, information

VS 3

61430

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓61

Registered No. 61430

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Cambridge ST
(c) Hospital or institution: Univ. Hosp. 21-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo 21 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1459 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Helen May Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
F	W	Married

6 (b) Name of husband ~~or wife~~ Lewis B. Brooks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 11th 1895

8. AGE: Years	Months	Days	If less than one day
53	1	9	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Bernard Beckhardt
13. Birthplace Germany

MOTHER
14. Maiden Name Helen (Unknown)
15. Birthplace Germany

16 (a) Informant Lewis Brooks
(b) Address 1459 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) MAR 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20 1948, at 4:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1 1948, to 3-20 1948 and that I last saw h[illegible] alive on 3-20 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to arteriosclerosis	
Due to diabetes mellitus	
Other Conditions Gangrene of foot	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard E. Reel M. D.
Address Univ. Hosp. Date signed 3-20-48

VS 150

Important: Physicians: please write the cause of death so that the correct age is especially important.

G61431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 186a

Registered No. G61431

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2314 Aisquith St
(c) Hospital or institution: 9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2314 Aisquith St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Haasen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife Emma

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) April 23rd 1873

8. AGE: Years	Months	Days	If less than one day
74	10	27	hr. min.

9. Birthplace Phila. PA.
(Town, county, and state)

10. Usual Occupation Time Smith Helper

11. Industry or business Penna R.R.

FATHER
12. Name Frederick L. Haasen
13. Birthplace Prussia

MOTHER
14. Maiden Name Elizabeth Beck
15. Birthplace Phila. Pa.

16 (a) Informant Mrs. Emma Haasen
(b) Address 2314 Aisquith St (Ca. 2094)

17 (a) Burial (b) Date thereof 5-25-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director Wm Cook Jr
(b) Address 1217 St Paul St

19 (a) MAR 22 1948
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1948, at 6 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intra pneumonic
Myocardial Degeneration

Due to

Other Conditions Fracture, left
Femur
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury Dec 26, 1947
(b) Where did injury occur? Wilmington, Del
(c) Did injury occur at home, on farm, industrial place, in public place? Railroad Station While at work? no
(d) Means of injury Slipped and fell down

23. Signature Carl L. Reiter M.D.
Medical Examiner.
Date signed 3-20-48

VS 151

475

correct age is especially important. Physicians are required by law to report promptly all deaths coming to their knowledge.

1432

SC-48-04512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 61432

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St.
(c) Hospital or institution: St. Josephs 8-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 day
(e) Length of stay in Baltimore (yrs., mos., or days) 21 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1338 N. Chester
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Knight

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/28/48

8. AGE: Years	Months	Days	If less than one day
		21	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Millard L Knight Sr
13. Birthplace Texas

MOTHER
14. Maiden Name Alma Walters
15. Birthplace Baltimore Md

16 (a) Informant Wm L Knight
(b) Address 1219 Hilford Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3/22/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Md
Location Baltimore Md

18 (a) Funeral director Millard Colton
(b) Address 1219 Hilford Ave

19 (a) MAR 22 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1948 at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/28 1948 to 3/20 1948 and that I last saw him alive on 3/20 1948.

Immediate cause of death	Duration
Respiratory Failure	1 Hr.
Due to Prematurity	21 Days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James S. Shottle M. D.
Address St. Josephs Date signed 3/20/48

Please write clearly, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 159

X

61433

AB-11862-

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 45F

× G61433 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days
(e) Length of stay in Baltimore (yrs., mos., or days) 23yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Edgemere
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7302 Back Front Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Wheeler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15- 1863

8. AGE: Years	Months	Days	If less than one day
84	5	6	hr. min.

9. Birthplace Mass. ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Wheeler
13. Birthplace France

MOTHER
14. Maiden Name Mary ?
15 Birthplace Canada

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/48 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Baltimore Md

18 (a) Funeral director Wilbur Coleman Co Inc
(b) Address 1217 E Pratt St

MAR 22 1948 (Date rec'd by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21- 1948, at 3.13A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-18- 1948, to 3-21- 1948, and that I last saw him alive on 3-21- 1948.

Immediate cause of death	Duration
Cardiac failure	24 hrs
Due to Cerebral hemorrhage	4 wks
Due to	
Other Conditions Gen arteriosclerosis	yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gordon Craft M. D.
Address Balt City Hosp Date signed 3/21/48

VS 150

correct age is especially important. Physicians, please write

×

G61434

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46B

Registered No. G61434

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1811 Wilkens ave
(c) Hospital or institution: 19-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 Wilkens ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie V. Fowler

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Harry M. Fowler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 17-1867

8. AGE: Years 80 | Months 4 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jesse N Williams
13. Birthplace Md

MOTHER
14. Maiden Name Unknown Recht
15. Birthplace Md

16 (a) Informant Mrs Henry Wiething
(b) Address 1811 Wilkens ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Geo L Beyer Jr
(b) Address 1512 Hollins St

19 MAR 22 1948 (b) Huntington Williams M.D. Registrar
(a) Date rec'd by Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1948, at 6 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1947, to March 20 1948, and that I last saw h[illegible] alive on March 19 1948.

Immediate cause of death Pneumonia Stomach Chronic Interstitial Nephritis — Duration

Due to — Duration

Due to — Duration

Other Conditions Hypertension Cancer — Duration 2 days
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. A. Darby

Address 117 Mulberry St Date signed 3/23/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G61435

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1310

Registered No. G61435

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 403 S Augusta ave
(c) Hospital or institution: 20-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 403 S Augusta ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James B. Coplin

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Rosa B. Coplin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 8-1879

8. AGE: Years 68 | Months 8 | Days 11 | If less than one day ... hr. ... min.

9. Birthplace W Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Anderson Coplin

13. Birthplace W Va

14. Maiden Name Martha Lowell

15. Birthplace W Va

16 (a) Informant Miss Anna Coplin

(b) Address 403 S Augusta ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Geo. L. Beyer Jr

(b) Address 1512 Hollins St

MAR 22 1948 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/19 1948, at 7:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to 3/19 1948 and that I last saw him alive on 3/18 1948.

Immediate cause of death: Intracranial hemorrhage — Duration: 2 days

Due to: C V D disease

Due to:

Other Conditions: Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alois H Larrowtton

Address 4109 Hudson ave Date signed 3/20/48 M. D.

correct age is especially important. Physicians: please write the cause of death plainly.

VS 150

X

661436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

661436 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. Where exact information is not known, give best possible answer. Be sure that you have given the correct age in each case. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Redwood Street
(b) Street address ~~923 Lorbin Ave.~~
(c) Hospital or institution: Univ. Hosp 114
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 923 Lorbin ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lee Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1889
8. AGE: Years 59 | Months | Days | If less than one day ____hr. ____min.
9. Birthplace Virginia (Town, county and state)
10. Usual Occupation formerly fireman
11. Industry or business

FATHER
12. Name James
13. Birthplace Virginia

MOTHER
14. Maiden Name Carolyn Banks
15. Birthplace Virginia

16 (a) Informant Lee Johnson
(b) Address

17 (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY MAR 18 1948

18 (a) Funeral director Commissioner of Health
(b) Address

MAR 22 1948 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1948 at 3:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1947 to Jan 10 1948 and that I last saw him alive on Jan 10 1947

Immediate cause of death Uremia — Duration

Due to Arteriosclerotic renal disease

Due to Generalized arteriosclerosis

Other Conditions Gangrene, Rt. leg, Hemiplegia, Left; mit-Stis (Include pregnancy within 3 months of death)

Date of operation Dec. 30(?)

Major findings of operation: arteriosclerosis Rt leg vessels; gangrene

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible]
M. D.
Address Univ. Hosp Date signed 1-11-48

VS 150

061437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registered No. 061437

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use no abbreviations. Fill in all blanks. Be sure and answer every question. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3034 Mc-Elderry St

(c) Hospital or institution: 7-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3034 Mc-Elderry St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret M. Kimfelder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~. Married

6 (b) Name of ~~husband~~ or wife George J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14 - 1892

8. AGE: Years 55 | Months 11 | Days 5 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER

12. Name Martin Fleischman

13. Birthplace Baltimore Md

MOTHER

14. Maiden Name Margaret

15. Birthplace Baltimore Md

16 (a) Informant George J. Kimfelder

(b) Address 3034 Mc-Elderry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/48 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart.

Location

18 (a) Funeral director John C. Moran

(b) Address 3000 E Baltimore St

19 (a) [illegible] (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1947, to Mar. 19 1948, and that I last saw deceased alive on Mar. 19 1948.

Immediate cause of death — Duration

Chronic Myeloid — 8 months

Due to Leukemia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence None at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Francis J. Januszeski M. D.

Address 540 N. Linwood Ave Date signed 3/19/48

661438

BC-48-06106

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. 661438

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 16-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 17
(d) Street No. 1829 Ridgely Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Nicholson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race N | 6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 3-11-48
8. AGE: Years | Months | Days | If less than one day 6 hr. — min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Tibbs
13. Birthplace — Md.

MOTHER
14. Maiden Name Louise Nicholson
15. Birthplace Balto. Md.

16 (a) Informant Louise Nicholson
(b) Address 1829 Ridgely Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location Johns Hopkins Medical School MAR 12 1948

18 (a) Funeral director Commissioner of Health
(b) Address
MAR 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-12 1948, at 1:4 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 3-11 1948 to 3-12 1948 and that I last saw h[illegible] alive on 3-12 1948

Immediate cause of death: Congenital Atelectasis — Duration

Due to: Prematurity (Weight 2 lbs 4 oz at birth)

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Lorin D. Bieber, M.D.
Address Provident Hosp. Date signed 3/17/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

VS 150

C61439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C61439

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 409 Whitridge Avenue
(c) Hospital or institution: 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 409 Whitridge Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E.W. ANSTINE

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years 85 | Months - | Days - | If less than one day ... hr. ... min.

9. Birthplace: Long Green Md.
(Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER
12. Name: Patrick Walsh
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Mary E. Roach
15 Birthplace: Ireland

16 (a) Informant: Mrs. Wm. Roach
(b) Address: 409 Whitridge Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/48 (month) (day) (year)
(c) Cemetery or crematory: St. John's
Location: Long Green

18 (a) Funeral director: WIEDEFELD AND SON
(b) Address: GREENMOUNT AVE & 22ND

19 (a) MAR 22 1948 (Date rec'd by Registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19th 1948, at 9:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 16, 1948 to Mar. 19, 1948.
and that I last saw her alive on Mar. 17, 1948.

	Duration
Immediate cause of death: Cerebral Hemmorhage	3 days
Due to: Arteriosclerosis	unknown
Due to: ------	
Other Conditions: Myocarditis	unknown

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Jos. W. Montgomery M.D.
Address 401 E. 25th. St. Date signed 3/20/48.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be careful to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

83a

661440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 661440

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be correct are is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 719 N. Mount St
(c) Hospital or institution: 16-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 719 N. Mount St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Brown

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Selmon Brown
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1891
8. AGE: Years: 56 yrs. Months: Days: If less than one day: hr. min.
9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Home Wife
11. Industry or business

FATHER
12. Name Robert Rice
13. Birthplace Va

MOTHER
14. Maiden Name Hannah Rice
15. Birthplace Va.

16 (a) Informant Selmon Brown
(b) Address 719 N. Mount St.

17 (a) Burial (b) Date thereof 3/23/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MT. CALVARY
Location West Post Balto. Md.

18 (a) Funeral director Metropolitan Funeral Homes Inc.
(b) Address 927 N. Mount St

19 (a) MAR 22 1948 (b)
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1948, at 4:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 1948 to March 19 1948 and that I last saw h alive on March 19 1948.

Immediate cause of death	Duration
Generalized Arteriosclerosis	
Due to	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Campbell M. D.
Address 722 N. Mount Street Date signed 3/25/48

VS 150

61441

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 106a

Registered No. 61441

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 219 E. Biddle St
(c) Hospital or institution: 11-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ~
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 219 E. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Tilghman Haugh

3 (b) If veteran, name war ~ | 3 (c) Social Security Account No. ~

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	

6 (b) Name of husband or wife Robert Haugh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4 1948

8. AGE: Years 99 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace Talbot Co Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Cooke Tilghman
13. Birthplace Talbot Co Md

MOTHER
14. Maiden Name Milcah S Kinnear
15. Birthplace Talbot Co Md

16 (a) Informant Mrs Daniel Dunott
(b) Address 219 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 23/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Henry W Jenkins & Sons
(b) Address McCulloh & Eutaw Sts

19 (a) MAR 22 1948 (Date rec'd by registrar) (b) Interment ~ Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20th 1948, at 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948 to March 20th 1948, and that I last saw h[illegible] alive on March 20th 1948.

Immediate cause of death	Duration
Pulmonary Oedema.	1 day
Acute Prostatis	2 days
Due to Ungradable Carcinoma	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. Eutaw M. D.
Address 300 N. Eutaw St Date signed March 22 1948

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

VS 150

061442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 061442

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 908 Sharp Street
(c) Hospital or institution: 23-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 908 Sharp Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Jeter Eskridge

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name unknown
13. Birthplace

MOTHER 14. Maiden Name unknown
15. Birthplace

16 (a) Informant Colleen Jameson
(b) Address 908 Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Isaac L. Bronstein
(b) Address 108 W Montgomery St

19 (Date rec'd by registrar) 2-22-1948 (Signature of Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1948 at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1948 to 18 1948
and that I last saw h alive on March 18 1948

Immediate cause of death — Duration

Due to Chronic Interstitial Nephritis — Indefinite prior

Due to —

Other Conditions Pulmonary Edema — Contributory
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Langdon Shelton M.D.
Address 908 S. Sharp St Date 2-22-1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

VS 150

G61443 Sye G61443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 538 W. Conway Street
(c) Hospital or institution: 22-V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 538 W. Conway Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Howard William Sye

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/15/1895

8. AGE: Years	Months	Days	If less than one day
52	10	3	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation L
11. Industry or business

FATHER
12. Name William Sye
13. Birthplace Md

MOTHER
14. Maiden Name Louisa Robinson
15. Birthplace Va

16 (a) Informant Marie Johnson
(b) Address 538 W Conway
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Balto Co
18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 1 W Montgomery St
19 (a) MAR 22 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1948 at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan - 10 1948 to Mar 18 1948, and that I last saw him alive on Mar 0 1948.

Immediate cause of death Acute Coronary Pneumonia — Duration

Due to

Due to

Other Conditions Chronic Endocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 1121 Sea Date signed 3/20/48 M. D.

VS 150

61444

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13-1 / 13a

Registered No. 66344

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 85 years

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore MD (If outside city or town limits, write RURAL and give town)
(d) Street No. 2407 Madison Ave (If rural give location)
(e) Citizen of foreign country? NS (Yes or No) If yes, name country None

3 (a) FULL NAME Essie Gough

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Fe | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/25/1898

8. AGE: Years 49 | Months 11 | Days 26 | If less than one day hr. min.

9. Birthplace Prince George Co. MD (Town, county, and state)

10. Usual Occupation Housewife Scott

11. Industry or business Md.

FATHER
12. Name Isaiah R. Scott
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Holland
15. Birthplace Md.

16 (a) Informant Mrs. Emma Mills
(b) Address 2407 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location A. A. Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 N. Biddle St.

19 (a) MAR 22 1948 (Month, day, and year) (b) Christopher Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/20 1948 at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11 1948 to 3/20 1948 and that I last saw her alive on 3/20 1948

Immediate cause of death	Duration
(a) Hypostatic Congestion	4
Due to (b) Bronchial-Lobar Pneumonia	
Due to (c) Anemia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Garner, M.D.
Address 1514 Division St Date signed 3/24/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Where none, or not known, so state. Fill in dates in full. Do not abbreviate. Ages must be given for children under one year. Physicians: please write the causes of death clearly and legibly.

VS 150

X

61445 D O A Acct Rowe

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓153

Registered 61445

PLEASE WRITE PLAINLY, with ink. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH: Released to Hosp
(a) Baltimore City, Maryland
(b) Street address 18-1
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-O-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 904 N. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ann Louise Jones
3 (b) If veteran, name war
3 (c) Social Security Account No. ✓
4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. ✓
6 (b) Name of husband or wife Robert
6 (c) If alive, give age 30 years
7. Birth date of deceased (mo., day, yr.) 1-15-17
8. AGE: Years 31 | Months 2 | Days 7 | If less than one day ..... hr. ..... min.
9. Birthplace Va (Town, county, and state)
10. Usual Occupation
11. Industry or business
MOTHER / FATHER
12. Name Spencer Davenport
13. Birthplace Va.
14. Maiden Name Bessie Dodd
15. Birthplace Va
16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (b) Date thereof 3-22-48 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Hebrew Mem
Location Balto. Co., Md
18 (a) Funeral director Mrs. Frances H. Hemsley
(b) Address 578 W. Biddle st.
19 (a) MAR 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19- 1948, at 9a M
21. I certify that death occurred on the date above stated; that I attended deceased from D-19-to A 19..., and that I last saw h... alive on ... 19...
Immediate cause of death Resp. Ceased
Due to Scleroderma
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature M. Brooke M. D.
Address A.H.H. Date signed 3-19-48
For S. C. J. Zotucki by X Howard J. Mallis, M.D.

VS 193

G61446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 97

Registered No. G61446

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CHARLES & 31ST ST.
(c) Hospital or institution: HOMEWOOD APTS 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. HOMEWOOD APTS. CHARLES & 31ST ST.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM CHARLES GEOGHEGAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-09-5671

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife CARLOTTA GEOGHEGAN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 22, 1878

8. AGE: Years	Months	Days	If less than one day
69	2	28	hr. min.

9. Birthplace BALTO. MD.
(Town, county, and state)

10. Usual Occupation VICE PRES.

11. Industry or business DAVISON CHEM. CO.

FATHER
12. Name Capt. WM. C. GEOGHEGAN
13. Birthplace MD.

MOTHER
14. Maiden Name CELINE CHANEY
15. Birthplace MD.

16 (a) Informant MRS. CARLOTTA GEOGHEGAN
(b) Address HOMEWOOD APTS.

17 (a) BURIAL (b) Date thereof 3/22/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LORRAINE
Location BALTO CO. MD.

18 (a) Funeral director WM J. TICKNER & SONS
(b) Address BALTO. MD

19 (a) MAR 22 1948 Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/20 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1948 to Mar 20 1948 and that I last saw h[illegible] alive on Mar 19 1948

Immediate cause of death	Duration
Coronary Thrombosis	about 4 hrs
Due to Coma	3 days
Due to Arterio Sclerosis	several years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Leslie Ewell M. D.
Address 2945 St Paul St Date signed Mar 22/48

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

VS 150

SHADUK.

661447

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 661447

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hosp. 26-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Dundalk Balto 22 (If outside city or town limits, write RURAL and give town)
(d) Street No. 6735 Roberts Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Anna Shaduk.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Louis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1889

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housf.
11. Industry or business

FATHER
12. Name ?
13. Birthplace Russia

MOTHER
14. Maiden Name ?
15. Birthplace Russia

16 (a) Informant Mr Louis Shaduk
(b) Address 6735 Robert Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 24/48 (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russian Cem Md
Location Philip's Mewing Sons
18 (a) Funeral director
(b) Address 2024 Orleans St
19 (a) MAR 22 1948 (Registrar's date of registration) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21 1948, at 12:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/16 1948 to 3/21 1948 and that I last saw her alive on 3/21 1948.

Immediate cause of death Card Resp Collapse — Duration

Due to Cerebral Thrombosis

Due to Hypertensive CVD

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A N Kaylor
Address Redwood & Greene Date signed 3/21/48 M.D.

VS 150

Please write plainly in ink. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

061448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 061448

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Be sure and correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7-2
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2430 E. Monument St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Conrad Reeder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. ✓

6 (b) Name of husband or wife late Emma Reeder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-16-78

8. AGE: Years 69 | Months 7 | Days 1 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Boiler-maker

11. Industry or business

FATHER
12. Name Charles Reeder
13. Birthplace Germany ?

MOTHER
14. Maiden Name Mary ?
15. Birthplace Germany

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 22 48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 (a) MAR 22 1948 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1948, at 3 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-13 1948, to 3/17 1948, and that I last saw him alive on 3/17 1948.

Immediate cause of death: Cerebro-vascular Accident — Duration 4 days
Due to: Cerebral Arteriosclerosis — Duration 4 yrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J Douglas Carroll M. D.
Address Johns Hopkins Hosp Date signed 17 March
J Douglas Carroll 1948

VS 150

61449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. 61449

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4414 Marble Hall Road
(c) Hospital or institution: 27-14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4627 Resurrection Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Betty - Jane Wood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 17-1924

8. AGE: Years	Months	Days	If less than one day
24	0	1	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Clarence L. Wood
13. Birthplace California

MOTHER 14. Maiden Name Deborah Baker
15. Birthplace Baltimore

16 (a) Informant Mrs. C. L. Wood
(b) Address 4414 Marble Hall

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Road

19 (a) MAR 22 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1948 at 11:20 P M

21. I certify that I took charge of the remains described above, held an Inq Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to illuminating Gas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 18, 1948 11:20 P M.
(b) Where did injury occur? 4414 Marble Hall Road
(c) Did injury occur at home, on farm, industrial place, in public place? Home of Father While at work? No
(d) Means of injury Opened burner on Gas range

23. Signature William J. Helfrich M.D.
Medical Examiner.
Date signed 3/22/48

PLEASE WRITE PLAINLY, with pencil or pen. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

VS 181

G61450 Jacobs
1700 Eutaw Place

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1318

Registered No. G61450

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2738 Hugo Avenue
(c) Hospital or institution: 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2738 Hugo Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: John W. Gray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Anne L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1877

8. AGE: Years 70 | Months 7 | Days 24 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business: Gas & Electric Co.

FATHER
12. Name: Benjamin Gray
13. Birthplace: Md.

MOTHER
14. Maiden Name: Agnes
15. Birthplace: Md.

16 (a) Informant: Mrs. Anna L. Gray
(b) Address: 2738 Hugo Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-48 (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: Baltimore

18 (a) Funeral director: Leonard J. Ruck
(b) Address: 5305 Harford Road, 14

19 (a) MAR 22 1948 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1948, at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 26 1946 to March 18 1948 and that I last saw him alive on March 18 1948.

Immediate cause of death: Myocarditis

Due to: adv. atherosclerosis

Due to:

Other Conditions: Chr. fibrotic T.B. - pulmonary

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Louis J. Jacob

Address 1700 Eutaw Pl Date signed 3-20-48 M. D.

VS 150

937

G61451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G61451

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 21-2
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 Carroll St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Duvall

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-18-3694

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6-1890

8. AGE: Years	Months	Days	If less than one day
58	2	14	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Plumbers Helper

11. Industry or business

FATHER
12. Name Charles E. Duvall
13. Birthplace Md

MOTHER
14. Maiden Name Ella Kline
15. Birthplace Md

16 (a) Informant Virgie I. Kniesel
(b) Address 814 Dorchester Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 23. 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location City

18 (a) Funeral director Mr. Mrs. John W. Teufel & Son
(b) Address 5311 Edmondson Ave

19 (a) MAR 22 1948 (Date received) (b) Huntington Williams, Registrar, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21 1948, at 9:40 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed 3/20/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G61452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G61452

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be complete and correct as required by law. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1639 S. Hanover Street
(c) Hospital or institution: 23-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1639 S. Hanover Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES B. SCHULTZ

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 30, 1865

8. AGE: Years 82 | Months 6 | Days 20 | If less than one day hr. min.

9. Birthplace Joppa Harford Co. Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Goepct Packing House

FATHER
12. Name John C. Schultz
13. Birthplace Halle, Germany

MOTHER
14. Maiden Name Margarth Susanna Anderson
15. Birthplace Jpppa, Harford Co. Md.

16 (a) Informant Mary C. Schultz
(b) Address 1639 S. Hanover Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 23, 1948 (month) (day) (year)
(c) Cemetery or crematory St. Stephen's
Location Bradshaw, Maryland

18 (a) Funeral director William Cook, Inc.,
(b) Address 1217 St. Paul Street

19 (a) MAR 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 20 1948, at 2:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11 1948 to 3/20 1948, and that I last saw h alive on 3/20 1948

Immediate cause of death	Duration
Cardiac Failure	
Due to Pneumonia	
Due to Arteriosclerotic Vascular Accident	over
Other Conditions Diabetes; Anemia Pernicious — (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 333 N. East Ave. Date signed 3/24/48 M. D.

VS 150

X

G61453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G61453

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford
(c) Hospital or institution: 9-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4224 Harford Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ella M. Merritt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, ~~married, widowed, or divorced~~: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) May 29 1857

8. AGE: Years: 95 | Months: 9 | Days: 21/22 | If less than one day: hr. min.

9. Birthplace: A. A. Co. Md (Town, county, and state)

10. Usual Occupation: Retired School Teacher

11. Industry or business: Howard Co.

FATHER
12. Name: Thomas M. Merritt
13. Birthplace: Md.

MOTHER
14. Maiden Name: Eliza A. Hawkins
15. Birthplace: Md.

16 (a) Informant: John R. Hutson
(b) Address: 282 Guilford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/48 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill
Location: A. A. Co. Md.

18 (a) Funeral director: Wm Bolz Inc
(b) Address: 129 E. Pratt St

19 (a) MAR 22 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 20 1948 at 8a M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1948 to March 20 1948. and that I last saw her alive on March 19 1948.

Immediate cause of death: Chronic Myocarditis — Duration: 3 years
Due to: Senility
Due to:
Other Conditions: Non-united fractured femur — 7 years
(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury: None

23. Signature: L. L. Grady M.D.
Address: 5106 Harford Rd Date signed: 3/20/48

VS 150

561454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 561454

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be complete and correct as to every item. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 337 E. Hamburg st
(c) Hospital or institution: 24-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 337 E. Hamburg st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Frazier

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-7786

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~.
Male	White	Married

6 (b) Name of ~~husband~~ or wife Mary Frazier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 28 1877

8. AGE: Years	Months	Days	If less than one day
70	4	22	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name James Frazier
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Martha Gary
15. Birthplace Balto. Md.

16 (a) Informant James V. Frazier
(b) Address 337 E. Hamburg St.

17 (a) Burial (b) Date thereof 3/24/48
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Western
Location Balto. Md.

18 (a) Funeral director William Cook Jne
(b) Address 1217 St. Paul St.

19 MAR 22 1948 Huntington Williams M.D.
(If death occurred in city) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 20th 1948, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 17 1948 to March 20 1948, and that I last saw him alive on March 20 1948.

Immediate cause of death: General arterio Sclerosis
Chronic Myocarditis — Duration 5 yrs / 5 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Melvin L. Solomon, M. D.
Address 129 S. Broadway Date signed 3/22/48

VS 150

G61455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G61455

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Cecil Avenue
(c) Hospital or institution: 9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 Cecil Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME VIOLETTE V. LUFF

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: George Luff

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1882

8. AGE: Years 66 | Months 0 | Days 16 | If less than one day hr. min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name ? Haag

FATHER — 13. Birthplace

MOTHER — 14. Maiden Name Emma Sauer

MOTHER — 15. Birthplace Maryland

16 (a) Informant Mr. Emil Schwakopf

(b) Address 1148 E. 2nd. St. Brooklyn, N. Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC

(b) Address NORTH AVE. & BROADWAY

19 (a) MAR 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH March 20, 1948, at 7.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 13 1948 to Mch 20 1948, and that I last saw her alive on Mch 20 1948

Immediate cause of death	Duration
Acute Dilatation of Heart	1 day
Due to Chronic Myocarditis	6 yrs
Due to	
Other Conditions Arterio Sclerosis	8 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E Gill Hall M. D.

Address 1631 E North Av Date signed 3/20/48

VS 150

X

61456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

S-61456 Registered No. 1318

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Baltimore Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 W. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EBERHARDT PREISSLER (~~Priestler~~)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1891

8. AGE: Years 55 | Months 7 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland (Town, county and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Otto Preissler
13. Birthplace Germany

MOTHER 14. Maiden Name Minnie Bergen
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Anna Preissler
(b) Address 1635 E. 33rd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/48 (month) (day) (year)
(c) Cemetery or crematory Louden Park
Location Frederick Road

18 (a) Funeral director L. Heemann & Son
(b) Address 6067 Harford Road

19 (a) 3-22-48 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19- 1948, at 9:05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary thrombosis, Pulmonary edema, Cirrhosis of liver; Esophageal varices, chronic pulmonary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D. Medical Examiner.
Date signed 3-19-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

VS 181

over

G61457

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1948

G61457
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street Address 16-4
(c) Hospital or institution: Franklin Square
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 716 N. Monroe (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert Wilson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, ~~or divorced~~
M	C	Married

6 (b) Name of husband or wife Lydia Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-18-1877

8. AGE: Years	Months	Days	If less than one day
71 70	7	4	hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation unemployed
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Martha Homes
15. Birthplace Va

16 (a) Informant Lydia Wilson
(b) Address 716 N. Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-48 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Balto National

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna ave

19 MAR 22 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22/48 19 , at 4:10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Sauer M.D. Medical Examiner.
Date signed 3/22/48

VS 151

X

G61458 Leymon H Chandler G61458

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 163H

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2609
(c) Hospital or institution: Balto City Hosp. D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3611 Foster Avenue
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Leymon Chandler

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Isabell Chandler
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) August 26, 1910

8. AGE: Years 37 | Months 8 7 | Days 5 26 | If less than one day ____hr. ____min.

9. Birthplace British West Indies
(Town, county, and state)

10. Usual Occupation Bartender

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace ?

MOTHER
14. Maiden Name Unknown
15. Birthplace ?

16 (a) Informant Mrs. Isabell Chandler
(b) Address 3611 Foster Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Gwynn Falls Road

18 (a) Funeral director Tilly & Zeiler Inc.
(b) Address 4031 Wolfe Street

19 (a) MAR 22 1948 (Date rec'd by registrar) (b) Huntington Wolfe, Registrar

VS 151

PLEASE WRITE PLAINLY, with ink. Do not abbreviate. Be sure that the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 21, 1948, at 7 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to Carbon Monoxide

Due to

Other Conditions Mental Dependency, alcoholism

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/21/48 at 2 A. M.
(b) Where did injury occur? 3611 Foster Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Inhalation of gas escaping from gas heater unlit

23. Signature Carl L. Taylor M.D.
Medical Examiner.
Date signed 3-22-48

X

G61459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G61459

1. PLACE OF DEATH: South Balto. Gen'l. Hosp.
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1351 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Howard Irvin Jessup

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race Negro

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Sophia

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) 10/31/1914

8. AGE: Years 33 Months 4 Days 20 If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Howard A. Jessup
13. Birthplace Va.

MOTHER
14. Maiden Name Mamie Smith
15. Birthplace Va.

16 (a) Informant Sophia Jessup
(b) Address 1351 N. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/48 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat
Location Md.

18 (a) Funeral director Geo. B. Kelson
(b) Address 303 Presstman St

MAR 22 1948

(Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20 1948, at 1:07 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above; and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH asphyxiation

Due to Drowning

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 25/5

(a) Date of injury 3-20-48 at 12:11 A.M.
(b) Where did injury occur? Range 13 Pier 7 Locust Point W. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? yes
(d) Means of injury found drowned

23. Signature Howard J. Mancini M.D. Medical Examiner.
Date signed 3-20-48

PLEASE WRITE PLAINLY, with ... correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 181

G61460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G61460
Registered No.

GM. 118100

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Dys
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 644 Peach Orchard Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joyce Stanley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife Collins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16 1907

8. AGE: Years	Months	Days	If less than one day
40	9	3	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Alexander Lockett
13. Birthplace Va.

MOTHER
14. Maiden Name Rose White
15. Birthplace Va.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3/25/48
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md.

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Pressman St

19 (a) MAR 22 1948 (b) Huntington Williams, M.D.
Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 19 - 1948, at 4.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3 - 11 - 1948 to 3 - 19 - 1948, and that I last saw her alive on 3 - 19 - 1948.

Immediate cause of death	Duration
Due to Uremia Glomerulo-nephritis	1 yr
Due to	
Other Conditions Hypertensive Cardiovascular Disease	1 yr

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. E. Robinson Jr. M. D.
Address Balto City Hosp. Date signed 3/20/48

PLEASE WRITE PLAINLY, with unfading ink. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 193

G61461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73a

Registered No. G61461

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1739 E. Balto St.
(c) Hospital or institution: 2-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1739 E. Balto St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frona Klos
3 (b) If veteran, name war No
3 (c) Social Security Account No. 212-10-6089A
4. Sex F. 5. Color or race W. 6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife John F.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb 4 1880
8. AGE: Years 68 Months 1 Days 17 If less than one day hr. min.
9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business Packing Co.
FATHER 12. Name
13. Birthplace Poland
MOTHER 14. Maiden Name Josephine Lapinska
15. Birthplace Poland
16 (a) Informant Lucille Harvey
(b) Address 1739 E. Balto St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 23 48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Germanhill Rd
18 (a) Funeral director Dippel Bros
(b) Address 1800 E. Lombard St
19 (a) MAR 22 1948 (Date received by registrar) (b) Huntington Nathanson, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1948, at 12 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1945, to March 21 1948 and that I last saw h[illegible] alive on 3/21/48 19

	Duration
Immediate cause of death Pernicious Anemia	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Milton F. Solomon, M.D.
Address 129 S. Irving Date signed 3/24/48

VS 150

G61462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G61462

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. Copy correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2109 N. Pulaski St
(c) Hospital or institution: 15-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 N. Pulaski St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vennie Erek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 10th 1868

8. AGE: Years	Months	Days	If less than one day
79	5	10	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Daniel Erek
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Katherine Clarkson
15. Birthplace Balto. Md.

16 (a) Informant Leslie E. Bley
(b) Address 224 Register Ave

17 (a) Burial (b) Date thereof 3/23/48
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) MAR 22 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 20th 1948, at 9a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1948 to Mar 20 1948, and that I last saw her alive on Mar 20 1948.

Immediate cause of death	Duration
Coronary Sclerosis	
Due to Senility & arteriosclerosis	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leslie E. Bley M. D.
Address 2033 W Northern Date signed 3/24/48

VS 150

G61463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 173

Registered No. G61463

PLEASE WRITE PLAINLY, WITH UNFADING INK. ENTRIES MUST BE MADE IN ALL ITEMS. Insert correct age if known. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7007 Fleet Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 4578 Yuma St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME Charles H. McARTHUR

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1912

8. AGE: Years	Months	Days	If less than one day
35	8 10	6 3	hr. min.

9. Birthplace Fort Slocum, N.Y. (Town, county, and state)
10. Usual Occupation Aviation Chief Machinist Mate U.S.N.
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant U. S. Gov't Records
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof March 22-1948 (month) (day) (year)
(c) Cemetery or crematory Fort Myer Chapel
Location Arlington Virginia

18 (a) Funeral director Robt. E. & B.M. Walter
(b) Address Pratt & Stricker Sts

19 (a) MAR 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1948, at 8:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection and Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-24-48 at ? 26/6 M.
(b) Where did injury occur? Chesapeake Bay
(c) Did injury occur at home, on farm, industrial place, in public place? At Sea While at work?
(d) Means of injury. Jump down Airplane crash

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 3/22/48

G61464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

Registered No. G61464

1. PLACE OF DEATH: 17-3

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution: University Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos

(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County.....

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 748 Pierce Street (If rural give location)

(e) Citizen of foreign country?.....(Yes or No)

If yes, name country.....

3 (a) FULL NAME Pleasant Broadus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Harriett Broadus

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1899.

8. AGE: Years 48 | Months 11 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace Summit, Virginia (Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER

12. Name Pleasant Broadus

13. Birthplace Virginia

MOTHER

14. Maiden Name Susan ?

15. Birthplace Virginia

16 (a) Informant Harriett Broadus

(b) Address 748 Pierce St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof March 24, 1948. (month) (day) (year)

(c) Cemetery or crematory.....

Location Fredericksburg, Virginia

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St

19 (a) (Date received by Registrar) (b) Funeral Director, Williams, Md. Registrar

MAR 22 1948

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20 1948, at 2 35 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to hisc death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of heart

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 3-20-48 12 15 A. M.

(b) Where did injury occur? 748 Pierce Street

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Sharp Instrument

23. Signature..... M.D. Medical Examiner

Date signed 3/20/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

661465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. 661465

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33-41 Calvert St.

(c) Hospital or institution: Union Memorial Hosp. 24-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 133dy

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto.

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 1412 Webster St. #30 (If rural give location)

(e) Citizen of foreign country? NC (Yes or No)

If yes, name country

3 (a) **FULL NAME** Peter J. Feimer | Peter J. Feimer

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-3912

4. Sex M

5. Color or race W

6 (a) Single, (married) widowed, or divorced JULIA - TILL

6 (b) Name of husband or wife JULIA-TILL

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 3, 1892

8. AGE: Years 55 | Months 7 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Hungary (Town, county, and state)

10. Usual Occupation Stevedore

11. Industry or business

FATHER

12. Name Adam Feimer

13. Birthplace Hungary

MOTHER

14. Maiden Name Susshman Marstoff

15. Birthplace Hungary

16 (a) Informant Hosp Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/48 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location adcs md

18 (a) Funeral director D. J. Foley & Sons

(b) Address 1318 Light St.

19 MAR 22 1948 (Date rec'd by registrar) Baltimore, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-21 1948, at 9.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 Nov. 1948, to 21 March 1948, and that I last saw him alive on 21 March 1948.

Immediate cause of death Pulmonary edema — Duration .....

Due to cachexia .....

Due to multiple myeloma .....

Other Conditions arteriosclerotic heart disease .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....

(e) Means of injury .....

23. Signature Charles Richard Benson M. D.

Address Union Memorial Hosp. Date signed 3-21-48

Chas. Richard Benson X

VS 199

G61466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G61466

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 904 E. BELVEDERE Ave

(c) Hospital or institution: 27-8

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 9 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 904 E. BELVEDERE Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY G. WALTHAM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOWED

6 (b) Name of husband or wife Otho L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN 31, 1879

8. AGE: Years	Months	Days	If less than one day
69	1	21/2	hr. min.

9. Birthplace Balto., MD (Town, county, and state)

10. Usual Occupation SCHOOL TEACHER

11. Industry or business (RETIRED)

FATHER

12. Name Wm. G. GROTHAUS

13. Birthplace GERMANY

MOTHER

14. Maiden Name MARY T. RICHTER

15 Birthplace Balto., MD.

16 (a) Informant MR. W. ALAN WALTHAM

(b) Address 301 ALABAMA RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/25/48 (month) (day) (year)

(c) Cemetery or crematory DRUID RIDGE

Location PIKESVILLE, MD.

18 (a) Funeral director Wm. J. PICKNEY & SONS

(b) Address BALTO., MD

19 (a) MAR 22 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22 1948, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944 to March 22 1948, and that I last saw h alive on 3/22 1948.

Immediate cause of death Myocarditis — Duration

Due to Hypertension — Years

Due to Arterio-Sclerosis — Years

Other Conditions — Years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Henry L. Hynson M. D.

Address 20 E. Preston St. Date signed 3/22/48

VS 159

X

661467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 47c

661467 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 9-6

(a) Baltimore City, Maryland

(b) Street address 33rd Calvert St.

(c) Hospital or institution: Union Memorial Hosp [illegible] Room

(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3008 Harford Rd (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country —

3 (a) FULL NAME MR. FRANCIS MARION MERRIKEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
M	W	

6 (b) Name of husband or wife ALVERTA E. MERRIKEN 6 (c) If alive age years

7. Birth date of deceased (mo., day, yr.) Oct 9, 1877

8. AGE: Years	Months	Days	If less than one day: hr.	min.
70	5	12		

9. Birthplace Maryland, Baltimore (Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business

FATHER 12. Name James Thomas Merriken

13. Birthplace Baltimore, Md

MOTHER 14. Maiden Name Elizabeth Lee

15. Birthplace Baltimore Md

16 (a) Informant Mrs. James Merriken

(b) Address 34 Dr Carlisle Ave

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/24/48 (month) (day) (year)

(c) Cemetery or crematory LOUDON PK.

Location Balto, MD.

18 (a) Funeral director Wm J. Tickner & Sons

(b) Address Balto, MD.

19 MAR 22 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-21 1948 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 5 1948 to MAR-21 1948 and that I last saw him alive on MAR 21 1948.

Immediate cause of death	Duration
Bronchiogenic Carcinoma	1 yr
Due to	
Due to	
Other Conditions Pneumonia atelectasis	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. A. Gregory Jr. M. D.

Address Union Memorial Hospital Date signed 3/21/48

VS 150

X

661468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 661468

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 16-5
(b) Street address
(c) Hospital or institution: West Balto Genr'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore, MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2329 Calverton Hgts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Otis Arthur Haines

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-01-4904

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife Regina L. Finkner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10, 1903

8. AGE: Years	Months	Days	If less than one day
44	6	2/11	hr. min.

9. Birthplace Balto Co. MD.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Delta Constrn Co.

FATHER
12. Name Edward G. Haines
13. Birthplace MD.

MOTHER
14. Maiden Name Laurel Figgins
15. Birthplace Va.

16 (a) Informant Mrs. Regina L. Haines
(b) Address 2329 Calverton Hgts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto., MD.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Baltimore, MD.

19 (a) MAR 22 1948 (Date received by registrar) (b) Interment or Removal Baltimore, MD.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-21 1948 at 6 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-9 1948 to 3-21 1948 and that I last saw him alive on 3-21 1948.

Immediate cause of death Subarachnoid Hemorrhage & Subdural Hematoma — Duration
Due to Aneurysm, Right Middle Cerebral Artery, Congenital
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide? To be Approved by Medical Examiner
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Gabrielsen, M.D.
Address 1411 Baltimore Comml Bk Date signed M. 3 D. 24/48
To be signed by Attending Physician, Coroner, Medical Examiner, Health Officer, or Hospital Superintendent

VS 150

061469

BALTIMORE CITY HEALTH DEPARTMENT

BC-48-0200 CERTIFICATE OF DEATH 107

Registered No. 061469

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. correct age is especially important. Physician: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1410 Filbert Dar St
(c) Hospital or institution: 25-J

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1410 Filbert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbera Thibault

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 26, 1948

8. AGE: Years	Months	Days	If less than one day
	1	23 26	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business

FATHER
12. Name Robert Thibault
13. Birthplace Conn.

MOTHER
14. Maiden Name Helen Roe
15. Birthplace Va.

16 (a) Informant Robt. Thibault
(b) Address 1410 Filbert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A.A. Co.

18 (a) Funeral director E. J. Tormey & Son
(b) Address 1938 E. Lafayette Ave

19 (a) MAR 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/20 1948, at 9:51 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. P. Sulkowski M.D.
Medical Examiner.
Date signed 3/20/48

X

G61470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 155

Registered No. G61470

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 5-1
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital DM
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1 N Spring St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Victoria Jackson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1948, at 1 05 PM

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Sarah Rodgers
(b) Address 413 N. Dallas St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 24 48 (month) (day) (year)
(c) Cemetery or crematory Mew Cathedral Cem
Location Frederick Road

18 (a) Funeral director Mrs. Pott & Elliott Sons
(b) Address 1129 N. Caroline St.

19 (a) MAR 22 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Osteitis deformans

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Helbeck M.D. Medical Examiner
Date signed March 21, 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G61471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

Registered No. G61471

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2-2

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1806 E. Bank St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Fabula

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-19-26

8. AGE: Years 21 | Months 4 | Days - | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Towing

11. Industry or business

MOTHER | FATHER

12. Name George Fabula

13. Birthplace Pa

14. Maiden Name Julia Mickel

15. Birthplace Pa

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-23-48 (month) (day) (year)

(c) Cemetery or crematory St Stanislaus Cem

Location Balto. City

18 (a) Funeral director John M. Weber

(b) Address 401 S. Chester Street

19 (a) [illegible] 22 1948 (b) Huntington Williamsport, Md

MEDICAL CERTIFICATION

35P

20. DATE OF DEATH March 19 1948, at 3 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/18 1948 to 3/19 1948 and that I last saw him alive on 3/19 1948.

Immediate cause of death: Heart failure, rheumatic — Duration: 7 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Douglas Carroll

Address Johns Hopkins Hosp. Date signed 5 March 1948

Douglas Carroll 1948

VS 150

614472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 614472

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Dunkirk Ave.
(c) Hospital or institution: 28-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4703 Dunkirk Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Nowakowski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Walter Nowakowski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17 1878

8. AGE: Years	Months	Days	If less than one day
69 70	9	4	hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER: 12. Name Thomas Pika
13. Birthplace Poland

MOTHER: 14. Maiden Name Mary Mandybal
15. Birthplace Poland

16 (a) Informant Stephen Nowakowski
(b) Address 4703 Dunkirk Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Balto. County

18 (a) Funeral director John Mc-Weber
(b) Address 401 S. Chester Street

19 (a) MAR 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1948, at 2 00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1948, to 3/21 1948, and that I last saw Her alive on Mar. 20 1948.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Chronic Myocarditis	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. J. Hernandez M. D.
Address 4709 Hurd Ave. Date signed 3/22/48

VS 150

X

G61473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Register No. G61473

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1806 E. Eager St.
(c) Hospital or institution: M-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1806 E. Eager St (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Elder Cyphus Walker

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Married

6 (b) Name of ~~husband~~ wife Henerietta Walker
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Jan 6 1853

8. AGE: Years	Months	Days	If less than one day
95	2	13	hr. min.

9. Birthplace Brunswick Co. Va (Town, county, and state)
10. Usual Occupation unemployed
11. Industry or business

MOTHER / FATHER
12. Name Robert Walker
13. Birthplace ?
14. Maiden Name unknown
15. Birthplace ?

16 (a) Informant Henerietta Walker
(b) Address 1806 E. Eager St

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 3 22 48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mitchells Cem.
Location Broadnex Virginia

18 (a) Funeral director Cayper Funders
(b) Address 1622 E. Preston St.

19 (a) MAR 22 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1948, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-18-1946 to 3-19-1948, and that I last saw ~~him~~ her alive on 3-18 1948.

Immediate cause of death Cerebral Accident — Duration 3 da
Due to Arteriosclerosis generalized — 2 yr
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. W. McDaniel M. D.
Address 807 N. Caroline Date signed 3-19-48

VS 150

X

G61474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 81

G61474
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 22-1
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dor
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 322 S. Charles St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME W. A. Polk

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced. ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1848

8. AGE: Years 50 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 15 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) MAR 22 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1948, at 9 30 P M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Second and third degree burns 70% of body

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-5-48 at ? 25/2 P M.
(b) Where did injury occur? 2 side of road Pikesville Md
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Clothes ignited from bonfire

23. Signature M.D. Medical Examiner.
Date signed 3-6-48

VS 151

G61475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

180

G61475 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 5-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 McElderry Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles WILLEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
?	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	?

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace ? (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School MAR 15 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (Date rec'd by registrar) MAR 22 1948 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24, 1948, at 6.15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection and Inq thereon and from the evidence obtained Autopsy, Inspection or Inquiry.
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Extensive burns.
~~Burns~~ Suffocation from inhalation of smoke.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 2-24-48 5 a. 5/2
(a) Date of injury 1107 McElderry Street M.
(b) Where did injury occur? Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury House afire

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 2/24/48

VS 191

661476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. 661476

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Catawba & Williamson Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Montgomery
(c) City or town Silver Springs
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Brother Kirby (Raymond C. Quinlan)

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 24-1927

8. AGE: Years 24 | Months — | Days 27 | If less than one day: hr. min.

9. Birthplace Kentucky (Town, county, and state)

10. Usual Occupation Scholastic

11. Industry or business

MOTHER / FATHER

12. Name Raymond L. Quinlan

13. Birthplace Louisville, Kentucky

14. Maiden Name Marie D. Veith

15. Birthplace Louisville, Kentucky

16 (a) Informant Laverian Brothers

(b) Address 4609 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 24-48 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Old Frederick Road

18 (a) Funeral director Chas. F. Evans & Son

(b) Address 118 W. Mt. Royal Ave,

19 (a) MAR 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 21 1948, at 11:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 9 1948, to Mar 21 1948, and that I last saw him alive on Mar 21 1948.

Immediate cause of death Acute Cardiac Failure — Duration: 4 Days

Due to Pneumonia — Duration:

Due to Rheumatic Heart disease — Duration: 2 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Brother [illegible]

Address 457-W Elm Ave Date signed 3/24/48

VS 150

(61477)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164c

Registered No. (61477)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 8.5
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2305 Harford Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond O. Campbell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1931

8. AGE: Years	Months	Days	If less than one day
17			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Raymond Campbell
13. Birthplace Va.

MOTHER
14. Maiden Name Frances Greenstreet
15. Birthplace Balto.

16 (a) Informant Frances Wilson
(b) Address 1858 Armstead

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Balto. Md.

18 (a) Funeral director Wm. Cook Inc
(b) Address 1217 St. Paul St.

19 (a) MAR 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1948, at 9:15 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wound of brain

Due to

Other Conditions Despondency.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-21-48 at 4 P. M.
(b) Where did injury occur? 2305 Harford Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fire-arm

23. Signature Howard J. Mendelsohn M.D. Medical Examiner.
Date signed 3-22-48

VS 151

X

661478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

661478 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1208 Cleveland St
(c) Hospital or institution: 21-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Cleveland St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Risher R. Gettier

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Howard F. Gettier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec 27th 1890

8. AGE: Years	Months	Days	If less than one day
57	2	23	hr. min.

9. Birthplace Annapolis Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name William Smith
13. Birthplace Annapolis Md.

MOTHER
14. Maiden Name Elizabeth Lamb
15. Birthplace Md.

16 (a) Informant Delores Schenneke
(b) Address 1208 Cleveland St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Bluff
Location Annapolis Md.

18 (a) Funeral director William Cook Inc.
(b) Address 121 St. Paul St.

19 MAR 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 20th 1948, at 7:18 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 27 Oct 1947 to 20 Mar 1948 and that I last saw h~~er~~ alive on 19 Mar 1948.

Immediate cause of death: Carcinoma of Colon — Duration: 6 mos.?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 31 Oct 47
Major findings of operation: Intestinal Obstruction due to Carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which deaths are to be charged statistically.

22. If death was due to external causes, fill in the following: No
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward F. Nolan M.D.
Address 682 Washington Blvd M.D. Date signed 20 Mar 48

VS 180

X

661479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH. 138

661479 Registered No.

AB-117914

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 431 Watty Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Married

6 (b) Name of husband or wife Grayson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28-1919

8. AGE: Years	Months	Days	If less than one day
29	-	20	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Lindsey-or-Lindsay
13. Birthplace Va.

MOTHER
14. Maiden Name Carrie Elkins
15 Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Wm. Geo. H. Hallgarth
(b) Address 1631 Druid Hill Ave.

19 (a) MAR 22 1948 (Date received by registrar) (b) Huntington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 19 48 at 1.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4- 1948, to 3-20- 1948, and that I last saw h... or alive on 3-20- 1948

Immediate cause of death	Duration
Tuberculosis pulmonary bilat; far advanced with cavitation	2 mos.
Due to	
Due to	
Other Conditions Pulmonary Edema	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Laurence Lee Jr. M. D.
Address Baltimore City Hosp Date signed 3-20-48

VS 150

G61480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

114E

G61480 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13-1
(c) Hospital or institution: Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2503 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Thomas Mayer

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1935

8. AGE: Years	Months	Days	If less than one day
13	-	17	hr. min.

9. Birthplace Baltimore, Md. (town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name James Mayers
13. Birthplace Va

MOTHER
14. Maiden Name Mattie Curtis
15. Birthplace Va

16 (a) Informant Mrs. Mattie Mayers
(b) Address 2503 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/1948 (month) (day) (year)
(c) Cemetery or crematory Arlington Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave

19 (a) Mar 22 1948 (Date received by Registrar) (b) Hunting for Baltimore Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20-1948 at 5 35 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary atelectasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D. Medical Examiner.
Date signed

VS 191

G61481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

53

G61481 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Hartford
(c) City or town Whiteford
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME Granville McAllister

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife Frances McAllister

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1904

8. AGE: Years 44 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Night Watchman

11. Industry or business

FATHER
12. Name John McAllister
13. Birthplace Md.

MOTHER
14. Maiden Name Frances Riley
15. Birthplace Md.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/48 (month) (day) (year)
(c) Cemetery or crematory Fawn Grove Pa.
Location York Co.

18 (a) Funeral director Hubert P. Harbaugh
(b) Address Delta, Penna.

19 Mar 22 1948 Huntington Williams M.D. (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22/48 19 , at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17 1948 to 3/22 1948, and that I last saw him alive on 3/22 1948.

Immediate cause of death Cerebral Edema due to Pulmonary Edema, due to Cardiac Arrest, due to Malignant Melanoma with Cerebral metastasis to Rt. Frontal - parietal region of brain. Duration

Due to

Due to

Other Conditions Bradycardia, Artificial Rt. Eye (Include pregnancy within 3 months of death)

Date of operation 3/10/48 Metastatic Melanoma

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis H. Mayo M.D.
Address University Hosp. Date signed 3/22/48 M. D.

VS 153

X

G61482

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G61482

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5 St. Martins Road
(c) Hospital or institution: 12-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 St. Martins Road
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country --------

3 (a) **FULL NAME** Charles French Blake, M. D.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Adeline O'Bryon
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr) Dec. 13, 1868

8. AGE: Years	Months	Days	If less than one day
79	3	7 6	-- hr. -- min.

9. Birthplace Athens, Ohio
(Town, county, and state)

10. Usual Occupation Medical Doctor

11. Industry or business -------

FATHER
12. Name Samuel B. Blake
13. Birthplace New Haven, Conn

MOTHER
14. Maiden Name Polly Camp
15. Birthplace New Haven, Conn.

16 (a) Informant Mrs. Adeline M. Blake
(b) Address 5 St. Martins Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/48 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) 3-22-1948 (Date received by registrar) (b) Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1948, at 5:09 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1947 to March 19 1948, and that I last saw h.im alive on Mar 18 1948.

Immediate cause of death Chronic Myocarditis. — Duration Indefinite

Due to

Due to

Other Conditions Coronary Sclerosis — Indefinite
Pulmonary embolism
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathaniel M. Beck, M.D.
Address 100 E. 23rd Date signed March 22-48

G61483

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G61483

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (~~year, month, or~~ days) 85
(e) Length of stay in Baltimore (~~year, month, or~~ days) 85

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town White Hall
(If outside city or town limits, write RURAL and give town)
(d) Street No. West of White Hall
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Archie Lowe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 1887

8. AGE: Years	Months	Days	If less than one day
60	6		hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Mr. Oliver Lowe
13. Birthplace Maryland

MOTHER
14. Maiden Name Rosie Grove
15. Birthplace Maryland

16 (a) Informant Mrs. Effie Lovard
(b) Address Md. Line, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 25, 1948 (month) (day) (year)
(c) Cemetery or crematory West Liberty
Location White Hall, Md R.D.

18 (a) Funeral director Jno. F. Hartsock's Sons
(b) Address Oliver Funeral Co.

MAR 23 1948 (Date rec'd by registrar) Huntingtown Williamsport Md

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1948, at 6 15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 29 1947 to March 22 1948 and that I last saw him alive on March 22 1948

	Duration
Immediate cause of death Bronchial pneumania	7 days.
Due to asperation	7 days.
Due to	
Other Conditions laryngeal palsy	1 year.

(Include pregnancy within 3 months of death)

Date of operation none.

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Glenn R. Grove

Address Union Memorial Hospital Date signed 3/24/48 M.D.

X

G61484

JL - 116191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH • 13

✓

Registered No. G61484

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave. 12-7

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.

(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2126 Maryland Ave. -18 (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Backlund

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Florence Church

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1911

8. AGE: Years	Months	Days	If less than one day
37	1	3	hr. min.

9. Birthplace Norway (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business King Cleaners

FATHER

12. Name Martin H. Backlund

13. Birthplace Norway

MOTHER

14. Maiden Name Mathea Gulbrensen

15 Birthplace Norway

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/24/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Cathedral

Location Balto Md

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

19 (a) MAR 23 1948 (Date rec'd by registrar) (b) Lexington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1948, at 8.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 29 1947, to March 20 1948, and that I last saw him alive on March 20 1948.

Immediate cause of death	Duration
Tuberculosis, pulmonary far advanced bilat	4 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.

Address Baltimore City Hosp Date signed 3-24-48

X

G61485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G61485

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp. 3-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 414 S. Balto. St.
(If rural give location)
(e) Citizen of foreign country? Bonds (Yes or No)
If yes, name country

3 (a) FULL NAME Lambru Stainovich (LANBRU STAINOVICH)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, ~~married, widowed, or divorced~~ Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 55 | Months | Days | If less than one day ....hr. ....min.

9. Birthplace Yugo Slavia
(Town, county, and state)

10. Usual Occupation Vendor

11. Industry or business Self

MOTHER FATHER
12. Name (Unknown) Stainovich
13. Birthplace "
14. Maiden Name "
15. Birthplace "

16 (a) Informant Paul Sansone
(b) Address 2 W. Pratt St.

17 (a) Burial (b) Date thereof 3/24/48
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 MAR 23 1948 (b) Huntington for Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1948, at 8:15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, ~~Inspection~~ or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl Lange M.D.
Medical Examiner

Date signed 3-24-48

C61486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. C61486

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING. Do not write in this space.
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 21 S. Exeter st
(c) Hospital or institution: 3-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 21 S. Exeter st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Cline

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~:
Female	White	Widowed

6 (b) Name of husband Louis Cline

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12th 1882

8. AGE: Years	Months	Days	If less than one day
65	9	8	hr. min.

9. Birthplace Norfolk Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name James Webb
13. Birthplace Suffolk Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace Richmond Va

16 (a) Informant Rev Lee M. Cole
(b) Address 21 S. Exeter st

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/23/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Mt. Carmel
Location Balto. Md.

18 (a) Funeral director Wm Cook Inc
(b) Address 217 St Paul st

19 MAR 23 1948 (Date received by Registrar) (Registrar)

VS 139

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 20th 1948, at 7:10 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945 to Mar 20th 1948, and that I last saw h alive on Mar 17th 1948.

Immediate cause of death	Duration
Coronary Heart - Insufficiency	
Due to arteriosclerosis	unknown
Due to Hypertension	
Other Conditions Arthritis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury Rare Thrombosis

23. Signature Mar 20th 1948
Address 193 E N Ave Date signed 3/20/48 M. D.

94a

G61487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G61487

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2109 Woodbourne Ave
(c) Hospital or institution: 27-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 Woodbourne Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie Belle Sears

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or divorced: Widowed

6 (b) Name of husband: Beauregard Sears

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec 9th 1865

8. AGE: Years: 82 Months: 3 Days: 12 If less than one day: hr. min.

9. Birthplace: A. A. Co. Md
(Town, county, and state)

10. Usual Occupation: at Home

11. Industry or business: " "

FATHER
12. Name: J. Trott
13. Birthplace: A. A. Co. Md.

MOTHER
14. Maiden Name: A. Sears
15. Birthplace: A. A. Co. Md.

16 (a) Informant: Joseph E. Sears
(b) Address: 704 E. 23rd St.

17 (a) Burial (b) Date thereof 3/25/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~: Baldwin
Location: Sirens Cross Rds

18 (a) Funeral director: Wm Cook Sons
(b) Address: 1217 St. Paul St

19 Date received by Registrar MAR 23 1948 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 21st 1948, at 5-45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from MAR 3 1948, to MAR 21 1948, and that I last saw her alive on MAR 21, 1948.

Immediate cause of death	Duration
Acute myocardial failure	
Due to Chronic myocarditis	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lloyd E. Taylor M. D.
Address 3902 Greenmount Ave. Date signed 23 Mar 48

VS 150

G61488

GM. 107390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G61488

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4040 Eastern Ave. 19-2

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Year

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1719 W. Lexington ST. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Beatrice Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Sep.

6 (b) Name of husband or wife Calvin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14 -1926

8. AGE: Years	Months	Days	If less than one day
21	7	7	hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Aisrail Marshall

13. Birthplace Florida

MOTHER

14. Maiden Name Martha Griffin

15 Birthplace N.C.

16 (a) Informant Records Balto. City Hospitals

(b) Address 4040 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-48 (month) (day) (year)

(c) Cemetery or crematory ZION Mt. Olivet Cemetery

Location Belair Rd

18 (a) Funeral director A. Shelstead

(b) Address 918 Lucille Ave

MAR 23 1948 (Date rec'd by registrar)

(b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 21 - 1948, at 5.40A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 - 7 - 1947 to 3 - 21 - 1948 and that I last saw her alive on 3 - 21 - 1948

	Duration
Immediate cause of death: Multiple myeloma	? 2 yrs.
Due to: Bronchopneumonia, rt. lower lobe	1 week
Due to: organism undet.	
Other Conditions: Pericardial Effusion Pyelitis, cystitis. (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.

Address Baltimore City Hosp. Date signed 3-22-48

X

VS 150

G61489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G61489

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Wyman Park apts
(b) Street address 40th St & Beech Ave
(c) Hospital or institution: 13-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. Beech Ave & 40th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Marian H. Fisher

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) 1873

8. AGE: Years	Months	Days	If less than one day
74	—	—	hr. min.

9. Birthplace Boston Mass (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Horace B Fisher
13. Birthplace —

MOTHER
14. Maiden Name M Adelaide Fisher
15. Birthplace —

16 (a) Informant Mr. D.K. Este Fisher
(b) Address 1012 N. Calvert St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Mar 23/48 (month) (day) (year)
(c) Cemetery or crematory Forest Hill
Location Boston Mass.

18 (a) Funeral director Henry W. Jenkins & Sons Co
(b) Address McCulloh & Orchard Sts

MAR 23 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1948, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to 3/21 1948, and that I last saw h[illegible] alive on 3/21 1948.

Immediate cause of death
Chronic Nephritis
Due to
Hemiplegia Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
Years
Years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry L. Hermon M. D.
Address 20 E. Preston St. Date signed 3/21/48

VS 150

X

C61490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

C61490 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lowland, Green Hts.

(c) Hospital or institution: University Hospital 18-3

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) 5yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1204 Hollins St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CORA MARIE PILKERTON (baptismal name). DIANE PILKERTON (REGISTERED NAME)

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife ✓

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 24th 1943

8. AGE: Years 5 | Months | Days 26 | If less than one day hr. min.

9. Birthplace Balto Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name James Pilkerton

13. Birthplace Back maryland

MOTHER 14. Maiden Name Katheryn Higgs

15. Birthplace Balt maryland.

16 (a) Informant James Pelkerton

(b) Address 1204 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem. Location 4300 Old Frederick Rd.

18 (a) Funeral director John J. Curran & Son

(b) Address 901-03 Hollins St.

MAR 23 1948 (Date rec'd by Registrar) (b) Huntington Williamsville, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1948, at 9:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 18 1948 to March 21 1948, and that I last saw her alive on March 21 1948.

Immediate cause of death

Cardio-respiratory failure

Due to Toxemia; shock

Due to 1°, 2° 3° Burns of face, body, & extremities

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 18-3

(a) Accident, suicide, or homicide Burns accident

(b) Date of occurrence March 18, 1948 at 9:45 AM

(c) Where did injury occur? Balto Md (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no

(e) Means of injury Clothes afire Playing with matches

23. Signature Joseph Shea

Address University Hospital Date signed 3/24/48

Dr. Wm H. Hammon Jr. Howard J. Nadell, M.D. Home Office

VS 153

GG1491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. GG1491

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1018 S. Kenwood Ave.
(c) Hospital or institution: 1-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1018 S. Kenwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viktoria Gielner

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Henry Gielner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Kucinski
13. Birthplace Poland

MOTHER
14. Maiden Name Unknowen
15. Birthplace Poland

16 (a) Informant Henry Gielner Jr.
(b) Address 1018 S. Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch. 24/48 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastern Ave.

19 MAR 23 1948 (Date received by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1948, at 7:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-15 1948 to 3-21 1948 and that I last saw her alive on 3-20 1948

Immediate cause of death	Duration
Arteriosclerotic C-V. Disease	2-15-48
Due to Parkinson Syndrome	2-15-48
Due to Congenital Goitre	3-18-48
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Schimunek M. D.
Address 8421 Eastern Ave. Date signed 3-22-48

VS 150

X

G61492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G61492

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: 14-2
(a) Baltimore City, Maryland
(b) Street address 1517 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1533 Argyle Ave. (If rural give location)
(e) Citizen of foreign country? None (Yes or No) If yes, name country None

3 (a) FULL NAME Mary V. Jones

3 (b) If veteran, name war None

3 (c) Social Security Account No.

4. Sex Fe

5. Color or race Negro

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Cyrus Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-29-1874

8. AGE: Years 73 | Months 9 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore MD. (Town, county, and state)

10. Usual Occupation Practical Nurse

11. Industry or business

FATHER
12. Name Thomas J. Harris Jrs.
13. Birthplace

MOTHER
14. Maiden Name Elizabeth Meads
15. Birthplace

16 (a) Informant Rev. Paul J. Harris
(b) Address 1704 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 3-27-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cema.
Location Balto, Co.

18 (a) Funeral director Mrs. Geo. W. Holland
(b) Address 1631 Druid Hill Ave.

19 MAR 22 1948 Date received by registrar [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17 1948, at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/12 1948, to 3/17 1948, and that I last saw her alive on 2/17 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Bronchopneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 2213 Druid Hill Ave. Date signed 3/19/48

VS 190

C61493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c ✓

Registered No. C61493

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3703 Belle Ave.,
(c) Hospital or institution: 15-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3703 Belle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Leo Reagan,

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1891

8. AGE: Years	Months	Days	If less than one day
56	4	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Accountant,
11. Industry or business Electric Mfg.

FATHER
12. Name Michael Reagan,
13. Birthplace Ireland.

MOTHER
14. Maiden Name Mary O'Brien,
15 Birthplace Norfolk, Va.

16 (a) Informant Mrs. G. I. Brandon,
(b) Address # 1 Upland Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral,
Location Baltimore City,

18 (a) Funeral director C. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.

MAR 23 1948 Huntington Williams, M.D.
(Date received by Registrar)

V S 150

MEDICAL CERTIFICATION 3.15 A.

20. DATE OF DEATH March 22 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1948 to 3/22 1948 and that I last saw him alive on 3/22 1948

Immediate cause of death	Duration
1) Rheumatic Carditis	
Vegetative Disease	5 yrs.
Due to with Embolus Fibrillation	7 days.
Due to	
Other Conditions Chronic Bronchitis	1 yr.

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl L. Chambers M. D.
Address 4108 Liberty Heights Date signed 3/22/48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1957

Registered No. G61494

G61494

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 19-2
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 N. Gilmor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert STOKES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Etta Stokes
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Feb 2, 1893

8. AGE: Years	Months	Days	If less than one day
55 54	1	18	hr. min.

9. Birthplace Greenville N. C. (Town, county, and state)
10. Usual Occupation Sailor
11. Industry or business

FATHER
12. Name Alonzo Stokes
13. Birthplace Greenville N. C.

MOTHER
14. Maiden Name Liza Harper
15. Birthplace Green Co. N. C.

16 (a) Informant Etta Stokes
(b) Address 107 N. Gilmor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md
18 (a) Funeral director Elroy B. Wilson
(b) Address 1100 Bloomsbury ave
19 MAR 23 1948 (Date rec'd by Registrar) Huntington Woodlawn Md

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1948, at 3:20 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Perforation of esophagus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 20 /48 3:20 A. M.
(b) Where did injury occur? Balto. Eye, Ear Nose Throat
(c) Did injury occur at home, on farm, industrial place, in public place? Hospital While at work? No
(d) Means of injury FOREIGN BODY IN THORAX Esophoguscope

23. Signature Chas G. Merrill M.D. Medical Examiner.
Date signed 3/30/48

VS 151

478

G61495

BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. G61495

CERTIFICATE OF DEATH 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14-1
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or ~~days~~) 7 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1903 EUTAW PL. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA LINDEMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, ~~married~~, ~~widowed~~, or ~~divorced~~

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 7. 1871

8. AGE: Years 76 | Months 10 | Days 15 | If less than one day ... hr. ... min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation home duties

11. Industry or business

MOTHER / FATHER

12. Name Henry Lindeman

13. Birthplace Balto.

14. Maiden Name Anna Rudeger

15. Birthplace Balto.

16 (a) Informant Geo. Lindeman

(b) Address 1903 Eutaw Place

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Mch 25/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location 3601 Frederick Ave

18 (a) Funeral director John O. Mitchell & Sons

(b) Address 1900 Eutaw Place

19 MAR 23 1948 (Date rec'd by Registrar) (Signature) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-22 1948, at 4:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-21 1948 to 3-22 1948 and that I last saw h[illegible] alive on 3-21 1948

Immediate cause of death CARDIO-RESPIRATORY FAILURE — Duration

Due to EITHER CEREBRO-VASCULAR ACCIDENT

Due OR UREMIA DUE TO ARTERIOSCLEROTIC KIDNEY DISEASE

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. L. Monow Jr. M. D.

Address Md. Gen. Hosp. Date signed 3-22-48

X

661496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. 661496

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Sydney (b) County Australia
(c) City or town Swanmore (If outside city or town limits, write RURAL and give town)
(d) Street No. 97 Corunna Road (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Mc Loughlin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/3/30

8. AGE: Years	Months	Days	If less than one day: hr.	min.
17	6	19		

9. Birthplace Australia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name David Mc Loughlen
13. Birthplace Australia

MOTHER
14. Maiden Name Minnie Isaac
15. Birthplace Australia

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/48 (month) (day) (year)

(c) Cemetery or crematory
Location Stanmore, Sydney, Australia.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1960 Eutaw Place

19 MAR 23 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1948, at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/14/1948 to 3/22 1948 and that I last saw him alive on 3/22/1948

Immediate cause of death	Duration
Cardiac Failure	1 hr
Due to Congenital Heart Disease	17 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation March 22 1948

Major findings of operation: Pulmonary Stenosis

of autopsy Pulmonary Stenosis, Partial Transposition of Vessels

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James R. Cantrell M.D.
Address Dr. Johns Hopkins Hosp Date signed Dr. Mar 48

VS 150

X

G61497 117923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G61497 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospital 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1639 N. Calhon St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Amanda Ellen Turner

3 (b) If veteran, name war XXXX

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife David

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1873

8. AGE: Years	Months	Days	If less than one day
75 74	1	9	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Benjamin
13. Birthplace Maryland

MOTHER
14. Maiden Name Amelia Bond
15 Birthplace Maryland

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Geo. U. Kelson
(b) Address 1303 Prestman St

MAR 23 1948 (Date rec'd by registrar)

(b) Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1948, at 9-10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 25 1948, to March 19 1948, and that I last saw her alive on March 19 1948.

Immediate cause of death: Cerebrovascular accident — Duration: 4 days

Due to:

Due to:

Other Conditions: Pernicious anaemia questionable — 4 mo

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. C. Robinson Jr M. D.
Address Balt City Hospitals Date signed 3/20/48

VS 130

G61498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G61498

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert

(c) Hospital or institution: Mercy Hospital 26-4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 113 N. Highland Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Andrew Flathemann (FLATHMANN)

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-01-4253

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Mrs Louise Flathemann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 23 1880

8. AGE: Years 68 | Months 2 1 | Days 30 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Unknown

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Unknown

MOTHER 15 Birthplace Maryland

16 (a) Informant wife

(b) Address 113 N. Highland ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 25/48 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Baltimore

18 (a) Funeral director Philip Hourigan

(b) Address 2024 Edmondson Ave.

19 MAR 23 1948 (b) Huntington Williams M.D. Registrar

VS 15b

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1948 at 8 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 22 1948 to March 22 1948. and that I last saw h. alive on March 22 1948

Immediate cause of death Asphyxia - H.C.V.D.

Due to Diabetes

Due to Cancer

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Myocardial infarction

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address Mercy Hospital Date signed March 22

C61499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. C61499

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2428 E. Monument St.
(c) Hospital or institution: 7-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2428 E. Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Lauro

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Catherine Lauro
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 29, 1864

8. AGE: Years	Months	Days	If less than one day
83	10	22	hr. min.

9. Birthplace Itlay (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Produce Dealer

FATHER
12. Name Frank Lauro
13. Birthplace Itlay

MOTHER
14. Maiden Name Theresa --
15. Birthplace Itlay

16 (a) Informant Mrs. Theresa Grob
(b) Address 2003 E. Monument St.

17 (a) Burail (Burial, cremation, or removal) (b) Date thereof Mar. 25/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto, Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 MAR 23 1948 (Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1947, to March 22 1948 and that I last saw him alive on 3/22 1948

Immediate cause of death: Acute Cardiac Failure — Duration 1 day

Due to: Arteriosclerotic Heart Disease — 5 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Israel Rosen M.D. M. D.
Address 2913 E. Monument St. Date signed 3/22/48

V S 150

G61500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G61500

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3049 Guilford ave
(c) Hospital or institution: 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3049 Guilford (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charlotta H. Rhein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16 1879

8. AGE: Years	Months	Days	If less than one day
68	9	6	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Henry Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Agusta Spatter
15. Birthplace Baltimore Md.

16 (a) Informant Elizabeth H. Heubach
(b) Address 31 Newbury Court - Ft

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location

18 (a) Funeral director Charles F. Powell
(b) Address 2427 Edmondson Ave

19 (a) MAR 23 1948 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 | 22 1948, at 1 10 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 | 1 1947 to 3 | 22 1948.
and that I last saw her alive on 3 | 22 1948.

Immediate cause of death: Pulmonary infarct — Duration: 1 week
Due to: Arteriosclerotic nephritis. — 5 mo.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert A. Reitz M. D.
Address 340 W. Madison St. Date signed 3/22/48

6150 ✓ 661501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item on this certificate must be answered to the extent of carefully supplied correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital ~~or Institution~~ St. Joseph's 8.5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 E. Lafayette (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Francis Hughes

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-6893

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
M.	W.	Single Married

6 (b) Name of husband or wife Elizabeth Hughes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1880

8. AGE: Years	Months	Days	If less than one day
67	4	27	hr. min.

9. Birthplace Baltimore Co. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Gilbert Jos. Hughes
13. Birthplace Md.

MOTHER
14. Maiden Name Bridget Fitzpatrick
15. Birthplace Md.

16 (a) Informant Wife Mrs. Elizabeth Hughes
(b) Address 1514 E. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Frederick Ave.

18 (a) Funeral director John F. Kenny
(b) Address Haleth & Fremont Sts.

MAR 23 1948 (Date filed by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21, 1948, at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 20, 1948 to Mar. 21, 1948 and that I last saw him alive on Mar. 21, 1948

Immediate cause of death Cardio Respiratory failure — Duration

Due to Arteriosclerotic Cardio-Vascular disease — Duration

Due to Generalized arteriosclerosis — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Hourahan M.D.
Address 1st Jos. Hosp. Date signed 3/24/48

VS 150

G61502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G61502

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1216 S. Clinton
(c) Hospital or institution: 26-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 S. Clinton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter A. Ptaszynski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Agnes W. Ptaszynski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10 1898

8. AGE: Years	Months	Days	If less than one day
49	4	11	hr. min.

9. Birthplace Mississippi (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business

FATHER
12. Name Alexander Ptaszynski
13. Birthplace Poland

MOTHER
14. Maiden Name Julia Zagzaski
15. Birthplace Poland

16 (a) Informant Agnes W. Ptaszynski
(b) Address 1216 S. Clinton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/48 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus Kostka
Location Dundalk Ave

18 (a) Funeral director Stephen J. Fealbowski & Co.
(b) Address 1000 S. Kenwood Ave

19 (a) (Date received by registrar) (b) Curtis Bay, Md.

MAR 23 1948
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 21 19 48, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from AUG. 22 19 46, to MARCH 21 19 48, and that I last saw h/m alive on 20 MARCH 19 48.

	Duration
Immediate cause of death: CORONARY OCCLUSION	3 HOURS
Due to HYPERTENSIVE CARDIOVASCULAR DISEASE	2 yrs.
Due to ARTERIOSCLEROSIS	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Nightstein M. D.
Address 12 [illegible] HAND AVE Date signed 3/24/48

G61503 — Lot Sec. 2 Range 6 Lot 6732 – 10 E. Biddle St. 2203 E. Baltimore St. — Sec 26/12

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G61503

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1121 Brentwood Ave.
(c) Hospital or institution: 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1121 Brentwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: James Edward Wood.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs. Gladys Wood | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7 – 1864

8. AGE: Years 83. | Months 4 | Days 15 | If less than one day hr. min.

9. Birthplace Knoxville Fred'k Co. Md. (Town, county, and state)

10. Usual Occupation Retired R.R Engineer

11. Industry or business

FATHER
12. Name Washington Wood.
13. Birthplace Fred'k Co. Md.

MOTHER
14. Maiden Name Mary Pottersfield
15. Birthplace Loudon Co. Va.

16 (a) Informant Mrs. M. Gladys Wood
(b) Address 1121. Brentwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 24/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto. Md.

18 (a) Funeral director Mamie Cook Syfer.
(b) Address 1600 W. North Ave.

19 MAR 23 1948 (Date rec'd by registrar) (b) Signature of registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 22 – 1948; at 7-18 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940. to Mar 22 1948.
and that I last saw h alive on Mar 21 1948.

Immediate cause of death: Diabetic Coma — Duration: 2 Days
Due to: Diabetes Mellitus — Duration: Years
Due to: Generalized Arteriosclerosis — Duration: Years
Other Conditions: Cerebral Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William R Knight M. D.
Address 10 E. Biddle St. Date signed 3/25/48

VS 150

C61507 Transcript mail to Jan 18 ✓ C61504

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2707 Hugo Ave.
(c) Hospital or institution: 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2707 Hugo Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William G. Weyraugh

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nellie M. Weyraugh | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3 1879

8. AGE: Years 68 | Months 9 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Retired Ins. Inspector

11. Industry or business

FATHER 12. Name Wm C. Weyraugh

13. Birthplace Balto Md

MOTHER 14. Maiden Name Elizabeth Rabein

15. Birthplace Balto Md

16 (a) Informant Mrs. Nellie M. Weyraugh

(b) Address 2707 Hugo Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/48 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem.

Location Baltimore, Md.

18 (a) Funeral director Maurice Cook Sykes

(b) Address 1606 W. Northern Pkwy.

19 (a) MAR 23 1948 (Date rec'd by registrar) (b) Tentatively for Williamsport, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1948, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to March 22 1948, and that I last saw him alive on March 22 1948.

Immediate cause of death: Cardio Vascular Renal — Duration: 2 yrs

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury:

23. Signature: Jas J Kinsey M. D.

Address 2700 Hartford Ave Date signed 3/23/48

VS 153

X

G61505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

Registered No. G61505

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4124 Reisterstown Rd.
(c) Hospital or institution: 15-13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4124 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert E. Wallis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	Widowed

6 (b) Name of husband or wife Late Margaret Wallis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1866.

8. AGE: Years	Months	Days	If less than one day
81	6	28	hr. min.

9. Birthplace England
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Wallis
13. Birthplace England

MOTHER
14. Maiden Name Unknown
15. Birthplace England

16 (a) Informant Mrs. Walter P. Guillett
(b) Address 4124 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/48. (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4301 Old Frederick Rd.

18 (a) Funeral director Harry H. Weitzle
(b) Address 4101 Edmondson Ave.

19 (a) MAR 23 1948 (Date rec'd by registrar) (b) Registrar for Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22/48 19 , at 89 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/47 19 , to 3/22/48 19 , and that I last saw h[illegible] alive on 3/22/48 19 .

Immediate cause of death	Duration
Cancer of Esophagus	4 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter P. Guillett
Address 4012 Edmondson Ave. Date signed 3/24/48 M. D.

VS 150

X

661506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

661506 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd.
(c) Hospital or institution: Garrison Nursing Home 15-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2803 Garrison Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara W. Dennis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W.	Widowed

6 (b) Name of husband or wife Late Thomas T. Dennis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1867

8. AGE: Years	Months	Days	If less than one day
80	7	3	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Wm. Wilderman
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Moore
15. Birthplace Mass.

16 (a) Informant Mrs. N. Clyde Marvel
(b) Address 104 W. University Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 23/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location 2930 Frederick Rd.

18 (a) Funeral director Harry A. Mustafa
(b) Address 4101 Edmondson Ave.

19 (a) MAR 23 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 22 1948, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1948 to Mar 22 1948, and that I last saw h[illegible] alive on Mar 21 1948.

Immediate cause of death	Duration
Myocardial insufficiency	10 days
Due to Pneumonia	3 days
Due to General depletion	years
Other Conditions Mental dis-turbance	years

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Clyde Marvel M.D.
Address 6 E. Biddle St Date signed 3/22/48 M. D.

VS 150

G61507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G61507

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1447 Washington Blvd.
(c) Hospital or institution: 27-18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5229 Linden Heights Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jesse L. Bitzer Sr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-10-1568

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Mary E. Lohmeyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 21, 1891

8. AGE: Years 56 | Months 5 mos | Days — | If less than one day hr. min.

9. Birthplace Baltimore County, Maryland (Town, county, and state)

10. Usual Occupation Operator

11. Industry or business Balto. Transit Co.

FATHER 12. Name William Bitzer

FATHER 13. Birthplace Balto. County Md.

MOTHER 14. Maiden Name Francis Myer.

MOTHER 15. Birthplace Balto Co. Md.

16 (a) Informant Mrs. Mary L. Bitzer

(b) Address 5229 Linden Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-48 (month) (day) (year)

(c) Cemetery or crematory Lorraine Cemetery

Location Woodlawn, Maryland.

18 (a) Funeral director Loring Bogley

(b) Address 5005 Park Heights Ave.

19 (a) [illegible] (b) [illegible] Washington Blvd

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1948, at 8:47 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 12 1948 to March 21 1948 and that I last saw h. alive on March 12 1948

Immediate cause of death: Coronary Occlusion — Duration: Sudden

Due to: Coronary Artery Disease — Duration: ?

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John P. Ulrich Jr M. D.

Address 2222 Druid Hill Ave'd Date signed 3/22/48

Howard J. Madeira, M.D.

V S 150

G61508

JARKIEWICZ

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G61508

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2327 Essex Street
(c) Hospital or institution: Home 1-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2327 Essex Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maryanna Jarkiewicz

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-05-2047

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband ~~or wife~~ John Deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct--1890?

8. AGE: Years 57 | Months 5 | Days | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Paul Wolak
13. Birthplace Poland

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Poland

16 (a) Informant Thaddeus Jarkiewicz
(b) Address 2327 Essex Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-48 (month) (day) (year)

(c) Cemetery ~~Essex~~ Holy Cross
Location Brooklyn A.A.Co.

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street

19 (a) MAR 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 March 1948, at 5 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to Hypertensive Cardio-Vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer, Jr. M.D. Medical Examiner.
Date signed 22 Mar. 48

VS 151

G61509

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G61509 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22-1
(c) Hospital or institution South Balto-Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 716 S Hanover St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Talbott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/21/1882

8. AGE: Years 65 | Months 10 | Days 29 | If less than one day hr. min.

9. Birthplace Greenwood S C (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Gas - Co.

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Ophelia Coleman
(b) Address 624 Barnes St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-(month) -48 (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co., Md

18 (a) Funeral director Isaac L Brown & Son
(b) Address 836 W Monteomery St

19 (a) MAR 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1948, at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earle Royer M.D. Medical Examiner.
Date signed 3/20/48

VS 151

G61510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G61510

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1703 Hope Street
(c) Hospital or institution: 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 Hope Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Sheridan

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1866

8. AGE: Years 81 | Months 5 | Days | If less than one day ____ hr. ____ min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Lumberjack

FATHER
12. Name Benjamin Sheridan
13. Birthplace New Jersey

MOTHER
14. Maiden Name Mary Dempsey
15. Birthplace New Jersey

16 (a) Informant Mrs. Catherine Dempsey (Sister)
(b) Address 1703 Hope Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road, Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) MAR 23 1948 (Date rec'd by registrar) (b) Interring for Williams, Md. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23rd, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947, to 3/22 1948, and that I last saw him alive on 3/22 1948.

Immediate cause of death Generalized Arteriosclerosis Arteriosclerotic Heart Disease — Duration 1520 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sol Smith

Address 1223 E Nor Date signed 3/23/48 M. D.

X

G61511

BALTIMORE CITY HEALTH DEPARTMENT ✓ X

CERTIFICATE OF DEATH 50

G61511 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 EDGEVALE RD
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Dorchester
(c) City or town CAMBRIDGE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 115 MILL ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY G. WINTERBOTTOM MILLS

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOWED

6 (b) Name of husband or wife JOHN G. MILLS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 20, 1867

8. AGE: Years	Months	Days	If less than one day
80	10	2	hr. min.

9. Birthplace CAMBRIDGE, MD.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name HARRISON T. WINTERBOTTOM
13. Birthplace MD.

MOTHER
14. Maiden Name MARY ELLEN PLUMMER
15. Birthplace MD

16 (a) Informant MRS. HAROLD TSCHUDI
(b) Address 504 EDGEVALE RD.

17 (a) BURIAL (b) Date thereof 3/24/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory CHRIST CH. CEM
Location CAMBRIDGE, MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTO., MD

19 (a) MAR 23 1948 (b) Turlington W. Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22/48 19.., at 3:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from NOV 21 1948, to 3/22 1948, and that I last saw h.er alive on 3/22 1948.

Immediate cause of death
Carcinoma of Breast — Duration 3 yrs.
Due to —
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Hellrich MD M. D.
Date 3/23/48
Address 610 6 Rutland Ave Balto 10

VS 150

G61512

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G61512
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1716 SULGRAVE
(c) Hospital or institution: 27-15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1716 SULGRAVE AVE (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Frank J. Norton

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: ?

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: MARY STAMER NORTON
6 (c) If alive, give age 47 years
7. Birth date of deceased (mo., day, yr.) 5/12/1882
8. AGE: Years 65 66 | Months 10 | Days 9 | If less than one day ..... hr. ..... min.
9. Birthplace Balto. MD. (town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business Roland Elec Co.
FATHER 12. Name Jotty C. NORTON
13. Birthplace BALTO. MD.
MOTHER 14. Maiden Name KATHARINE St. LEDGER
15. Birthplace BALTO, MD
16 (a) Informant MISS KATHARINE NORTON
(b) Address 1716 SULGRAVE AVE
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/24/48 (month) (day) (year)
(c) Cemetery or crematory DRUID RIDGE
Location TOWSON MD.
18 (a) Funeral director Wm. J. TICKNER & SON
(b) Address BALTO., MD.
19 (a) MAR 23 1948 (Date rec'd by registrar) (b) Registration No. Williamsville, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 Mar. 1948 at 10:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Due death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to Arteriosclerotic Cardio-Vascular Disease.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D. Medical Examiner.
Date signed 22 Mar. 1948

VS 151

G61513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G61513

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 709 E 41ST ST.
(c) Hospital or institution: 9-1
(d) Length of stay in ~~hospital or last~~ (yrs., mos., or days) ABOVE ADDRESS 4 YRS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 E. 41ST ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARTHA E. OWINGS

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: NO

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: WIDOWED
6 (b) Name of husband or wife: JAMES T.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) JAN 8, 1865
8. AGE: Years 83 | Months 2 | Days 14 | If less than one day hr. min.
9. Birthplace BALTO. MD. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business (a) Home

FATHER
12. Name UNKNOWN GRIFFITH
13. Birthplace MD

MOTHER
14. Maiden Name ELIZABETH OWINGS
15 Birthplace MD.

16 (a) Informant Miss MATTIE S. OWINGS
(b) Address 709 E 41ST ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/25/48 (month) (day) (year)
(c) Cemetery or crematory LORRAINE
Location BALTO CO., MD.

18 (a) Funeral director Wm. T. TICKNER & SONS
(b) Address Balto., MD.

19 (a) MAR 23 1948 (Date received by Registrar) (b) Huntington Hillsborough, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22 1948, at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 18 1948 to Mar. 22 1948 and that I last saw her alive on Mar 21 1948.

Immediate cause of death: Lobar Pneumonia — Duration: 5 days
Due to: Hypertension
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Earl F. Beeman, M.D.
Address 511 York Rd Date signed 3/22/48 M. D.

VS 180

G61514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G61514

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 854 W North Ave
(c) Hospital or institution: at Home 13-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED
(a) State Md (b) County Balto City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 854 W. North Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel May Chapman

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none
3 Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Frank S. Chapman
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) DEC-25-1877
8. AGE: Years 70 | Months 2 | Days 26 | If less than one day hr. min.
9. Birthplace New Haven - Conn (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Sherman Lindsley
13. Birthplace Conn.

MOTHER
14. Maiden Name Cannot ascertain
15. Birthplace " "

16 (a) Informant Frank S. Chapman (Son)
(b) Address 854 W North (17)
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-48 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore
18 (a) Funeral director Sherwood Morrow
(b) Address 108 W Mt Royal Ave.
MAR 23 1948 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 March 1948, at 2:15 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946 to March 1948 and that I last saw her alive on 22 March 1948.

	Duration
Immediate cause of death: Cerebral Hemorrhage	1 hr.
Due to: Arteriosclerotic Hypertension	
Cardio Vascular disease	years.
Due to:	
Other Conditions: Angina Pectoris	
Symptoms	2 years.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Laureston L. Reaves M.D.
Address 1938 Linden Ave Date signed 22 March 48

VS 150

C61515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C61515

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline
(c) Hospital or institution: St Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Severna Park, Md (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Sansing Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Mamie E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan 9-1904

8. AGE: Years	Months	Days	If less than one day
44	2	12	hr. min.

9. Birthplace Atlanta Georgia (Town, county and state)
10. Usual Occupation Guard
11. Industry or business Western Elec Co

FATHER
12. Name Jessie C. Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Julia Lanagy
15. Birthplace Md.

16 (a) Informant Mrs. Mamie Smith
(b) Address Severna Park Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto

18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Rd

19 (a) MAR 22 1948 (Date received by registrar) (b) Remington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21/48 19 , at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10/48 19 , to 3/21/48 ,
and that I last saw him alive on 3/21/48 .

Immediate cause of death Cardio Resp. failure — Duration
Due to eucherxia
Due to metastasis
Due to carcinoma lung
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hilda A Bailey M. D.
Address Josephs Hosp Date signed 3/21/48

G61516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

G61516 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27-4
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3307 Glenmore Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sigurd Andrew Lee

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 3-1938

8. AGE: Years 9 | Months 4 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER 12. Name Sigurd Lee

13. Birthplace Norway

MOTHER 14. Maiden Name Carolyn E. Andersen

15. Birthplace Md.

16 (a) Informant Mr. Sigurd Lee

(b) Address 3307 Glenmore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/48 (Month) (Day) (Year)

(c) Cemetery or crematory Lakewood Baltimore

Location

18 (a) Funeral director L. Leck

(b) Address 530 S. Mayford Rd.

19 (a) MAR 23 1948 (Date received by registrar) (b) Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-22- 1948 at 6 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/22/48 at 5:15 P.M.
(b) Where did injury occur? 6000 blk. of Benton Heights Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury fell into uncovered well

23. Signature Carl L. Kyler M.D. Medical Examiner.
Date signed 3-24-48

VS 151

G61517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G61517

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution: Maryland Gen'l. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mon.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County BALTIMORE
(c) City or town PIKESVILLE (If outside city or town limits, write RURAL and give town)
(d) Street No. 103½ Old Court Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Fannie B. Widerman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex FEMALE | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife FRANK E. WIDERMAN

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) JUNE 27-1880

8. AGE: Years 67 | Months 8 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace Union Bridge, Md. (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name JESSIE LIVINGTON KING
13. Birthplace WESTMINISTER, Md

MOTHER
14. Maiden Name Francis Virginia Spurrier
15. Birthplace Mt. Airy, Maryland

16 (a) Informant FRANK E. WIDERMAN
(b) Address 103½ Old Court Rd. PIKESVILLE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/48 (month) (day) (year)
(c) Cemetery or crematory Asbury M.E.
Location REISTERSTOWN, Md.

18 (a) Funeral director Frank H. Neurly
(b) Address Pikesville, Maryland

19 (a) MAR 23 1948 (Date rec'd by registrar) Huntington Williamson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22 1948 at 7:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/21 1948 to 3/22 1948, and that I last saw her alive on 3/22 1948.

Immediate cause of death: Chronic debility with general collapse

Due to: Abdominal lympho-sarcoma

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 2/25/48

Major findings of operation: abdominal lymphosarcoma

of autopsy: same

Duration: 1 Month

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John E Muller M. D.
Address Maryland Gen'l Hosp. Date signed 3/24/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

661518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. 661518

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution: 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 Ethan St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Vinnie H. Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-3064

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Edith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-21-1898

8. AGE: Years 50 | Months 2 | Days - | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business Md. Yacht Club

FATHER 12. Name John Henry Wilson

13. Birthplace Md.

MOTHER 14. Maiden Name Emma Hopper

15. Birthplace Md.

16 (a) Informant Clara Lewis

(b) Address 218-W. Reed St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary.

Location W. Halsted

18 (a) Funeral director Reed & Nelson

(b) Address 918-

19 (a) MAR 23 1948 (Registrar's signature) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 19 48, at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 3-15-48 at 7 25/4 M.

(b) Where did injury occur? Harbor-Md. Yacht Club

(c) Did injury occur at home, on farm, industrial place, in public place? Harbor While at work? yes

(d) Means of injury Found drowned

23. Signature Howard J. Mueller M.D. Medical Examiner.

Date signed 3-22-48

VS 151

G61519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G61519

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 10-2
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 825 Forrest Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME (Myles Myles) MUYERS LYERS

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-22-9923

4. Sex [redacted] 5. Color or race Colored

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Julia Muyers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7

8. AGE: Years 57 SMT | Months | Days | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation porter

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace ne

MOTHER
14. Maiden Name Unknown
15. Birthplace ne

16 (a) Informant Julia Muyers
(b) Address 825 Forrest St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 21 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.A. Co. Md

18 (a) Funeral director Pfaff & Weishaar
(b) Address 515 McElderry St

19 (a) MAR 23 1948 (Date rec'd by registrar) (b) Huntington West Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20- 1948 at 12 P.M 30

21. I certify that I took charge of the remains described above, held an Inspection of Body (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. F. Helfrich MD / H. H. Merrill M.D. Medical Examiner
Date signed 3/22/48

VS 151

661520

661520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓166

Registered No. 661520

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 5-1
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 East Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lewis Phillips

3 (b) If veteran, name war —

3 (c) Social Security Account No. 238-22-6213

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife Vera phillips
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1900

8. AGE: Years	Months	Days	If less than one day
27	8		hr. min.

9. Birthplace Ayden NC (Town, county, and state)
10. Usual Occupation Sailor
11. Industry or business

MOTHER / FATHER
12. Name Louis phillips
13. Birthplace Ayden N.C.
14. Maiden Name Edna Dell
15. Birthplace Ayden N.C.

16 (a) Informant Vera phillips
(b) Address 627 N. Carolina St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 26 1948 (month) (day) (year)
(c) Cemetery or crematory Ayden Cemetery
Location Ayden N.C.

18 (a) Funeral director Robert E. Williams
(b) Address 1515 McElderry St

19 (a) MAR 23 1948 (Date rec'd by registrar) (b) Huntington Hall Funeral Home Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-22-1948, at 9 55 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet-wound of left chest, diaphragm, stomach, liver, kidney, and spinal cord.

~~Due to~~

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/21/48 at 12:05 A. M.
(b) Where did injury occur? Eden & Lombard Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 3/22/48

VS 151

G61521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193

Registered No. G61521

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2338 Eutaw Place
(c) Hospital or institution: 27-15
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) Over 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Mt. Washington
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. The Terraces (If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country ---------

3 (a) FULL NAME John MARSHALL JONES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Jeannette Shriver
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) --------- 1865

8. AGE: Years	Months	Days	If less than one day
83			____ hr. ____ min.

9. Birthplace Alexandria, Virginia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Investment & Banklin

FATHER
12. Name Thomas Marshall Jones
13. Birthplace Virginia

MOTHER
14. Maiden Name Elizabeth Payne
15. Birthplace Virginia

16 (a) Informant Mrs. Jeannette S. Jones
(b) Address 1604 Terrace Road, Mt. Wash.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) MAR 23 1948 (Date rec'd by registrar) Registrar for Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1948, at 8:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertrophy and dilatation of heart, with acute congestive
Due to cardiac failure.

Other Conditions Generalized arteriosclerosis.
History of Electric shock therapy
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 3-22-48 at 8:00 P.M.
(b) Where did injury occur? 2338 Eutaw Place
(c) Did injury occur at home, on farm, industrial place, in public place? Dr's Office While at work? no
(d) Means of injury Electric shock therapy.

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 3/23/48

VS 181

661522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

661522 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5709 Bluebird Lane
(c) Hospital or institution: 26-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Balto. 24 Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 5709 Bluebird Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marian Banks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: George Banks

6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Sept. 12-1920

8. AGE: Years 27 | Months 6 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace Fauquier Hammonds Va (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name James Richey
13. Birthplace Essex Co. Va

MOTHER
14. Maiden Name Lillian Epps
15. Birthplace Essex. Co. Va

16 (a) Informant George Banks
(b) Address 5709 Bluebird Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/48 (month) (day) (year)
(c) Cemetery or crematory Sharon
Location Kingswood, Va.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Blantyre Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1948, at 1 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 23rd 1947 to March 22 1948 and that I last saw h[illegible] alive on March 22nd 48

Immediate cause of death: Pulmonary Tuberculosis — Duration: 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. H. Thomas M.D. M. D.
Address Turners Sta. Md Date signed 3/25/48.

VS 130

X

G61523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G61523

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Hilton St. 20-7
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 100 N. - Hilton St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME John L. Steib

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-24-9223

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	White	Widowed

6 (b) Name of husband or wife Bertha Steib
6 (c) If alive, give age 5. years

7. Birth date of deceased (mo., day, yr.) 9 - 22 - 1872

8. AGE: Years	Months	Days	If less than one day
75	5	27	— hr. — min.

9. Birthplace Annapolis - Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Pittsburg Glass Sil.

FATHER
12. Name John Steib
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Mrs. Freda M. Cogburn
(b) Address 100 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 23 MAR 48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore. Md.

18 (a) Funeral director E. B. Weippert & Son
(b) Address 1209 Eutaw Place

19 (a) MAR 23 1948 (Date rec'd by registrar) (b) Hunting for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 20 - 1948, at 1:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945 19 45 to March 20 19 48 and that I last saw him alive on March 20 19 48.

Immediate cause of death	Duration
Coronary occlusion	2 hrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Collum
Address 3821 Federick Date signed 3/22/48 M. D.

VS 183

X

G61524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G61524 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1527 Argyle Av
(c) Hospital or institution: 14-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1527 Argyle Av (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary J. Short

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife Sylvester Short
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 3, 1894

8. AGE: Years	Months	Days	If less than one day
53	5	16	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John B. Gould
13. Birthplace Md

MOTHER
14. Maiden Name Anna Webb
15. Birthplace Md

16 (a) Informant Sylvester Short
(b) Address 1527 Argyle Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Druid Hill Av

19 (a) MAR 24 1948 (Date rec'd by Registrar) (b) Huntingdon Williams M.D. (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/19 1948 at 6:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1948 to March 19 1948, and that I last saw h[illegible] alive on March 17 1948.

Immediate cause of death	Duration
Chronic Myocarditis	1 year
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. B. Hurst Jr. M.D.
Address 410 W. Biddle St Date signed 3/23/48

VS 189

G61525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G61525

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Tell correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5406 St. Albans Way
(c) Hospital or institution: 27-12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5406 St. Albans Way (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martha Verney Burchall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: William Burchall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1863

8. AGE: Years 85 | Months 82 | Days 0 | If less than one day 6 hr. min.

9. Birthplace: Howard County, Maryland (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business: Sept

FATHER
12. Name: Phillip Harmon
13. Birthplace: Anne Arundel County, Maryland

MOTHER
14. Maiden Name: Eliza Buchingham
15. Birthplace: Howard County, Maryland

16 (a) Informant: Richard H. Turk
(b) Address: 5406 St. Albans Way

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 3/26/48 (month) (day) (year)
(c) Cemetery or crematory: Lorraine
Location: Woodlawn, Maryland

18 (a) Funeral director: Wm. Cook, Inc.
(b) Address: 1217 St. Paul Street

19 MAR 24 1948 (Date rec'd by Registrar) Burlington Wisconsin

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1948, at 12:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to 3/23 1948 and that I last saw h[illegible] alive on 3/23 1948

Immediate cause of death: Hypertension
Cardio Vascular
Pneumonia

Duration

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature McCord Godley

Address 5703 Harford Rd Date signed 3/25/48

VS 153

C61526

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 77c

C61526
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp 4-1 DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 730 E Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lott William Brown

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-01-4254

4. Sex	5. Color or race	6 (a) ~~Single, married, widowed,~~ or divorced.
M	[redacted]	Divorced

6 (b) Name of ~~husband or~~ wife Mattie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 20th 1888

8. AGE: Years	Months	Days	If less than one day
59	7	0	hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business

FATHER
12. Name (Unknown) Brown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Lottie M. Kirby
(b) Address 349 S. Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/48 (month) (day) (year)
(c) Cemetery or crematory LORRAINE [redacted]
Location a. a. Co. Md.

18 (a) Funeral director Wm Cook Inc.
(b) Address 217 St. Paul St.

19 MAR 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1948, at 12:47 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry), find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D. Medical Examiner.
Date signed 24 Mar 48

G61527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G61527 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3012 Clifton Park Terrace
(c) Hospital or institution: 8-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3012 Clifton Park Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irene H. Kenney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife William C. Kenney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 7, 1877

8. AGE: Years	Months	Days	If less than one day
71	2	16	hr. min.

9. Birthplace Philadelphia, Pennsylvania
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Hauser
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Sophia Elphthal
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Henry Rohmer
(b) Address Northwood Apartments

17 (a) Burial (b) Date thereof 3/26/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore County, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 MAR 24 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1948, at 4:25 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1936 19 to 3-23 1948, and that I last saw h[illegible] alive on 3-20 1948

Immediate cause of death: Acute Heart Failure
Due to: Malnutrition
Due to: Cancer (Adeno-Carcinoma intestine)
Due to: Peritonitis
Due to: Ruptured appendix
Other Conditions

Duration: 2 days, 3 wks, 6 mos., 4 yrs ago, 4 yrs ago

(Include pregnancy within 3 months of death)
Date of operation 1944
Major findings of operation: Ruptured appendix, Peritonitis 1944
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William L. Feamy
Address 3025 Belair Rd Date signed 3-23-48

VS 150

G61528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195c

Registered No. G61528

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 14-1
(b) Street address
(c) Hospital or institution: 1411 Eutaw Place
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1411 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan F. McDonnell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5 Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1873

8. AGE: Years: about 75 Months: Days: If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

MOTHER / FATHER

12. Name James E. McDonnell

13. Birthplace Ireland

14. Maiden Name Ellen Lynsella

15. Birthplace Ireland

16 (a) Informant Mrs. John McCarthy

(b) Address 1411 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/48 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 217 St. Paul St.

19 MAR 24 1948 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1948, at 5:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 1948, to March 22 1948, and that I last saw h[illegible] alive on March 20 1948.

Immediate cause of death: Cardiac Insufficiency — Duration

Due to: Arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Leyson M. D.

Address 1 W E North Ave Date signed 3/23/48

VS 150

Samuel Leyson

G61529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G61529

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2222 E. Oliver St
(c) Hospital or institution: 8-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2222 E. Oliver St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaretha Buttner
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Walter Buttner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19 1883

8. AGE: Years	Months	Days	If less than one day
65		2	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Dautsch
13. Birthplace Germany

MOTHER
14. Maiden Name Margaretha Leicht
15. Birthplace Germany

16 (a) Informant Gertrude Buttner
(b) Address 2222 E. Oliver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 - 24 - 48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave

18 (a) Funeral director John E. Melly Son
(b) Address 2435 E Oliver St

MAR 24 1948 (Date received by registrar) Christopher Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 21 - 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 29 May 1946 to 21 March 1948 and that I last saw h[illegible] alive on 21 March 1948

Immediate cause of death	Duration
Myocardial failure (insufficiency)	1-2 years
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 1513 N. Milton Ave Date signed 3 Mar 48

VS 150

G61530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G61530

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. TYPE correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1404 Hollbrook St 9-9
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1404 Hollbrook St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian E. Keller

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles F. Keller

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Feb. 13 1890

8. AGE: Years 57 | Months 11 | Days 9 | If less than one day: hr. min.

9. Birthplace: Balto., Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George C. McMann
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Virginia McCleary
15. Birthplace Balto. Md.

16 (a) Informant Charles F. Keller
(b) Address 1404 Hollbrook St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-48 (month) (day) (year)
(c) Cemetery or crematory Carroll Chapel Mem. Park
Location Pulaski Highway

18 (a) Funeral director John C. Miller Inc.
(b) Address 2435 E. Oliver St

19 Filed MAR 24 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22 1948, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/23 1945 to 3/22 1948 and that I last saw her alive on 3/22 1948.

Immediate cause of death: Cirrhosis of Liver. — Duration: 7

Due to:

Due to:

Other Conditions: Arteriosclerosis, Cardio-vascular Renal disease
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph S. Blum M. D.
Address 1206 E. Lexington Date signed 3/24/48

VS 150

G61531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G61531

BC- 48-07343 159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Sinai Hospital
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave.
(c) Hospital or institution: 15-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2308 Anoka Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Silverman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Baby

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/21/48

8. AGE: Years	Months	Days	If less than one day
		1	14 hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name Max Silverman
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Gertrude Furst
15 Birthplace Baltimore Md

16 (a) Informant Max Silverman
(b) Address 2308 Anoka Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 24, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave
18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 MAR 24 1948 (Date received by Registrar) (Signature of Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23 1948, at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/21 1948 to 3/23 1948 and that I last saw h.r alive on 3/23 1948.

Immediate cause of death	Duration
Respiratory Failure	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Goldstein M. D.
Address Sinai Hospital Date signed 3/23/48

G61532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1210

Registered No. G61532

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Guilford Avenue
(c) Hospital or institution: 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2803 Guilford Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES EDGAR KIRK

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: WIDOWER

6 (b) Name of husband or wife: Anna M. Kirk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 16, 1868

8. AGE: Years: 79 | Months: 3 | Days: 6 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business: Ship Chandlar

FATHER
12. Name: Samuel E. Kirk
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Martha Cole
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. John Weller
(b) Address: 2803 Guilford Avenue -18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/ /48 (month) (day) (year)
(c) Cemetery or crematory: Lorraine
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) MAR 24 1948 (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22 1948, at 9.30P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1947 to 3/22 1948 and that I last saw h[illegible] alive on 3/22 1948.

	Duration
Immediate cause of death: Myocardial degeneration	4 yrs
Due to: Arter. Int. Nephritis	10 yrs
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Howard L. Todd M. D.
Address: 2108 St Paul St Date signed: 3/23/48

VS 150

G61533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G61533

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2717 The Alameda
(c) Hospital or institution: 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2717 The Alameda
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM EDGAR BROWN

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 212-07-0470

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1880

8. AGE: Years 67 | Months 2 | Days 23 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation C.P.A.

11. Industry or business New Amsterdam Casualty

FATHER
12. Name John Brown
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Cynthia Neilson
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Emma C. Adams
(b) Address 2717 The Alameda

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) MAR 24 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1948, at 4.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/21/48 1948 to 3/21 1948 and that I last saw h[illegible] alive on March 21 1948

Immediate cause of death: Myocardial Infarction — Duration: 3 Days
Due to Chronic Arteriosclerosis — 10 yrs
Due to Myocardelis — 5 yrs
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Erik Zimmerman M. D.
Address 9552 Harford Rd. Date signed 3/23/48

VS 130

G61534

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13-1 / 131a

Registered No. G61534

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40+ yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2416 Eutaw Pl (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Schwaber Joseph

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Rebecca

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years 83 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace: Austria (town, county, and state)

10. Usual Occupation: Painter

11. Industry or business

FATHER
12. Name: David
13. Birthplace: Austria

MOTHER
14. Maiden Name: Frieda
15. Birthplace: Austria

16 (a) Informant: Milton Schwaber
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-48 (month) (day) (year)
(c) Cemetery or crematory: Rosedale
Location: Phila Pike & Hamilton Ave

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 2100 Eutaw Pl

19 MAR 24 1948 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23/48 1948, at 7:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/18 1948 to 3/23 1948 and that I last saw h. l. alive on 3/22 1948

	Duration
Immediate cause of death: Uraemia	1 wk
Due to: Chronic kidney disease (? arteriolonephrosclerosis)	5 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: H. Schwaber M.D. M. D.
Address: Sinai Hospital Date signed 3/23/48

(G61535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

Registered No. G61535

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 344 Baker St
(c) Hospital or institution: 18-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 2317 N. Arlington Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2317 Arlington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Nugent
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 4 - 1896
8. AGE: Years 51 Months 8 Days 16 If less than one day hr. min.
9. Birthplace Pula (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

MOTHER FATHER
12. Name Thomas Nugent
13. Birthplace Unknown
14. Maiden Name Hyacinta Brown
15. Birthplace Pula

16 (a) Informant Grace Franklin
(b) Address 344 Baker St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 25 48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn
18 (a) Funeral director Wm Brooks
(b) Address 1463 N. Carey St
19 MAR 24 1948 Huntington Williams, M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/20/48 19 at 3:30 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 3/18/48 19 to 3/20/48 19, and that I last saw her alive on 3/20/48 19

	Duration
Immediate cause of death Endocarditis	
Due to Influenza	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Helen F. Conlon M. D.
Address 1012 Edmondson Ave Date signed 3/22/48

VS 150

G61536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93

Registered No. G61536

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 705 W. Lexington St.
(c) Hospital or institution: 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 705 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Ediger

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 218-01-3112

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 9-25-1895

8. AGE: Years 52 | Months 5 | Days 26 | If less than one day hr. min.

9. Birthplace Millville - New Jersey
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Veterans Administration
(b) Address Calvert Bldg.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 24-48 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Balto Md.

18 (a) Funeral director Ellsworth Amyard
(b) Address 3911 Liberty Heights Ave

19 (a) MAR 24 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1948, at 2:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl A. Ryan M.D.
Medical Examiner
Date signed 16 Mar 48

VS 151

G61537 #1 #4c
BCH #C 93066

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157E

X G61537
Registered No. 161176

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians—please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7306 Belair Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Shirley Lee Vaughan
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Infant

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/3/47

8. AGE: Years	Months	Days	If less than one day
	4½	21	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name J. E. Vaughan
13. Birthplace Md

MOTHER
14. Maiden Name Virginia Smith
15. Birthplace Md

16 (a) Informant Mr. J.E. Vaughan, Jr.
(b) Address 7306 Belair Road JOHNS HOPKINS HOSPITAL

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 3/25/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Lanahan Funeral Home
(b) Address 7401 Belair Road

MAR 24 1948 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24 1948, at 4:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 1948 to 3/24 1948, and that I last saw her alive on 3/24 1948

Immediate cause of death	Duration
Anopexia	Life
Due to Coma, Heart Disease Cyanotic	
Due to	
Other Conditions ? Aspiration	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Pulmonary Edema
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address Johns Hopkins Hosp. Date signed 3/24/48

VS 150

G61538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. G61538

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Calif. (b) County
(c) City or town San Pedro
(If outside city or town limits, write RURAL and give town)
(d) Street No. 935 23rd Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harold (F.E.J.) (Isbell) Shell

3 (b) If veteran, name war

3 (c) Social Security Account No. 549-24-6414

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1948, at 11:45 P M

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1916

8. AGE: Years	Months	Days	If less than one day
32			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name

13. Birthplace

MOTHER
14. Maiden Name

15. Birthplace

16 (a) Informant Mrs Arthur Johnson

(b) Address 6 Orange Cove

17 (a) Burial (Burial, cremation, or removal)

(b) Date thereof 3/24/48 (month) (day) (year)

(c) Cemetery or crematory Long Beach

Location Long Beach Calif

18 (a) Funeral director Wilson Funeral Home

(b) Address 124 W 4th St

(c) Filed MAR 24 1948 (Date received by registrar) Huntington Williams Registrar

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Sea death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-21-48 at 10:50 4/2 P M.
(b) Where did injury occur? Pier #6 - Pratt St.
(c) Did injury occur at home, on farm, industrial place, in public place? Harbor While at work? no
(d) Means of injury Found drowned

23. Signature Howard J. Waldron M.D.
Medical Examiner.

Date signed 3-22-48

VS 151

G61539

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G61539

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland – Balto. Md.
(b) Street address 202 Enfield Rd.
(c) Hospital or institution: 27-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) Home
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO. MD. (If outside city or town limits, write RURAL and give town)
(d) Street No. 202 ENFIELD RD. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WALLACE JAMES SMITH

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mamie M. Smith
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) JULY 10, 1880

8. AGE: Years	Months	Days	If less than one day
67	8	13	...hr. ...min.

9. Birthplace Reading, Penna. (Town, county, and state)
10. Usual Occupation Executive Drug Bus.
11. Industry or business Read Drug & Chem. Co.

FATHER
12. Name William Smith
13. Birthplace Reading, Pa

MOTHER
14. Maiden Name Sara Tragle
15. Birthplace Reading, Pa.

16 (a) Informant B. J. Hood M.D.
(b) Address 317 Broxton Rd. Balto.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/26/48 (month) (day) (year)
(c) Cemetery or crematory DRUID RIDGE
Location PIKESVILLE, MD.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address BALTIMORE, MD.

19 MAR 24 1948 (Date rec'd by Registrar) Washington Williams, M.D. Registrar

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 23 1948, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1946, to 3-22 1948.
and that I last saw h.i.m alive on 3-22 1948.

Immediate cause of death	Duration Sue Chron
Coronary Occlusion	
Due to Chronic myocardial	2 years
Due to Disease.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. J. Hood M. D.
Address 2200 Garrison Blvd. Date signed 3-23-48

X

G61540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G61540 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WITH PENCIL, WITH UNFADING INK.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 212 STONEY RUN 27-17 LA.

(c) Hospital or institution: HILLCREST NURSING HOME

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 6019 BELLONA AVE (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MOLLIE HEHL WOLLMAN

3 (b) If veteran, name war: No

3 (c) Social Security Account No. No

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: DIVORCED

6 (b) Name of husband or wife: EDWARD C. WOLLMAN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 3, 1866

8. AGE: Years 81 | Months 4 | Days 20 | If less than one day hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

MOTHER / FATHER

12. Name LOUIS HEHL

13. Birthplace GERMANY

14. Maiden Name HENRIETTA GROSS

15 Birthplace GERMANY

16 (a) Informant MISS BERTHA HEHL-(SISTER)

(b) Address 6019 BELLONA AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/26/48 (month) (day) (year)

(c) Cemetery or crematory LOUDON PK.

Location BALTO. MD.

18 (a) Funeral director WM. J. PICKNER & SONS

(b) Address BALTIMORE, MD

MAR 24 1948 (Date rec'd by registrar) (Name) for Williamson M.E.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 1946, to March 23 1948, and that I last saw h[illegible] alive on March 22 1948

Immediate cause of death	Duration
Acute Respiratory failure	
Due to Hypostatic pneumonia Myocardial insufficiency	
Due to	
Other Conditions Central hemorrhages with left hemiplegia terminal stage	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Howland Edward Day M. D.

Address 4-E-33rd St Balto 18 Date signed 3/23/48

VS 190

93E

C61541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C61541

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3718 Milford Ave
(c) Hospital or institution: 28-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3718 Milford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Augusta E. Kunst

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Alexander Kunst
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jul 22, 1867

8. AGE: Years: 80 | Months: 6 | Days: 0 | If less than one day: hr. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Mrs. Herbert Kunst (Daughter-in-law)
(b) Address: 3718 Milford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/48 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Baltimore, Md.

18 (a) Funeral director: Wm J. Tickner & Sons
(b) Address: Balto. Md.

19 MAR 24 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. (Registrar)

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22/48, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 19 1948 to March 22 1948 and that I last saw h[illegible] alive on March 19 1948.

Immediate cause of death	Duration
1) Arteriosclerosis - Selerosis cerebri - Vascular Disease	10 yrs.
Due to: Generalized Arteriosclerosis -	10 yrs.
Due to: Selerosis -	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
Autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Earl L. Chambers M. D.
Address 4108 Liberty Hts Date signed 3/23/48

61542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 92a

Registered No. CG1542

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 HARFORD RD. 8.5
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2301 HARFORD RD.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ELLEN SHOCKEY

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife CHARLES L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 25, 1876

8. AGE: Years 71 70 | Months 2 | Days 27 | If less than one day hr. min.

9. Birthplace FRANKLIN Co., PA.
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business —

FATHER 12. Name ALBERT MILLER

13. Birthplace PA.

MOTHER 14. Maiden Name LAURA WOLFE

15. Birthplace PA.

16 (a) Informant MRS. OLIVE J. CARLE

(b) Address 720 CHAPEL GATE LA.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/25/48 (month) (day) (year)

(c) Cemetery or crematory LOUDON PARK

Location BALTIMORE, MD.

18 (a) Funeral director WM. J. TICHNER & SONS

(b) Address BALTO. MD.

19 (a) MAR 24 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22/48 ~~19~~ at ~~11~~ A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 20 1948. to March 22 1948. and that I last saw her alive on March 21, 1948

Immediate cause of death	Duration
Acute Intestinal Obstruction.	2 days.
Due to Mesenteric Thrombosis	2 "
Due to	
Other Conditions Aortic Regurgitation. Left Hemiplegia. (Include pregnancy within 3 months of death)	2 yrs.

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 1613 E. North Av. Date signed 3-23-48

VS 150

99

61543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 61543

2C-48-06262 159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 15-7

(a) Baltimore City, Maryland

(b) Street address: Caton Ave & Wilkens Ave.

(c) Hospital or institution: St. Agnus Hosp Baltimore

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County U.L.A.

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3301 Elgin Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Baby Boy Wall [RONALD EDWARD WALL]

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/21/48

8. AGE: Years | Months | Days | If less than one day 1½ hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Roger E. Wall

13. Birthplace Md.

MOTHER 14. Maiden Name Eliz. Botts

15. Birthplace Md.

16 (a) Informant Hospital Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Balto. Md.

18 (a) Funeral director William J. Tuckwood Son

(b) Address North & Edmondson Aves

19 (a) MAR 24 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21/48 19 at 11:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/21/48 to 3/21/48 and that I last saw h alive on 19

Immediate cause of death Prematurity 4 mos gestation

Due to

Due to

Other Conditions Malformation of hair lip & cleft palate

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature L. N. D'Elia Sr M. D.

Address St Agnes Hosp Date signed 3/23/48

VS 156

G61544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓107

G61544 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway + Fairmount
(c) Hospital or institution: Church Home + Hospital 16-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore Co
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 760 Edgewood Street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Olga M. Bedford ✓

3 (b) If veteran, name war No | 3 (c) Social Security Account No. None

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Robert W. Bedford
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) July 22, 1897

8. AGE: Years 50 | Months 9 | Days 1 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Mr William Hart
13. Birthplace Unknown

MOTHER
14. Maiden Name Fanny M. Hart
15. Birthplace Unknown.

16 (a) Informant MS Amnons
(b) Address Church Home. Hosp.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/48. (month) (day) (year)
(c) Cemetery or crematory LORRAINE
Location Balto Co. MD.

18 (a) Funeral director Wm J. Tickner + Sons
(b) Address Balto. Md.

MAR 24 1948 (Date rec'd by registrar) (b) Huntington Whitique M.D. Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1948, at 12:4 A PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 20 1948 to Mar 23 1948, and that I last saw her alive on Mar 23 1948

Immediate cause of death Bronchopneumonia — Duration 3 days
Due to acute Bromide Poisoning
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Kirk Moore M.D. M. D.
Address Church Home + Hospital Date signed 3-22-48

Med. Exam. [illegible] Howard J. Malone M.D. X

G61545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G61545 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett ave.
(c) Hospital or institution: 20-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 W. Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Brimmer
3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 7, 1863

8. AGE: Years	Months	Days	If less than one day
84	9	14	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name John Brimmer
13. Birthplace Md

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mr. Charles C. White
(b) Address 1915 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Harry H. White
(b) Address 2101 Edmondson Ave

19 (a) Date received by registrar 1948 (b) Washington Williams, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/15 1948 to 3/21 1948, and that I last saw h[illegible] alive on 3/24 1948.

Immediate cause of death Chronic Myocarditis — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Tyler Bolley, M. D.
Address 503 Harford Ave Date signed 3/23/48

G61546

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G61546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 124 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1165 Carroll St
(c) Hospital or institution: 21-V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1165 Carroll St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Tapking

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	late widow

6 (b) Name of husband or wife late Frederick W. Tapking 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 7, 1872

8. AGE: Years	Months	Days	If less than one day
75	4	15	14 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name — Sugar
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia —
15. Birthplace Germany

16 (a) Informant Mrs Anna Dickerson
(b) Address 1165 Carroll St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3501 Fredrick Ave.

18 (a) Funeral director Harry A. Witzke
(b) Address 4101 Edmondson Ave

19 MAR 24 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 19 48 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19 48 to March 24 19 48.
and that I last saw her alive on March 24 19 48

Immediate cause of death: Acute Myocardial Infarct — Duration: days

Due to: Atherosclerotic Cardiovascular Disease — 5 mos

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify kind of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 700 E Pratt Date signed 3/26/48

VS 150

X

BC- G 75245

G61547?

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 161a

Registered No. G61547

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1711 E. Balto. St.
(c) Hospital or institution: 2-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stephen A. Connie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Infant

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31, 1941

8. AGE: Years	Months	Days	If less than one day
0	11	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Melvin Connie
13. Birthplace Tangier, Va.

MOTHER
14. Maiden Name Jessie Waddell
15. Birthplace Berlin, N.Y.

16 (a) Informant Mrs. Jessie Connie
(b) Address 1711 E. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 24, 1941 (month) (day) (year)
(c) Cemetery or crematory Lakewood
Location 4100 Edmondson Ave.

18 (a) Funeral director Dudell & Riggle
(b) Address 312 E. Highland Ave

19 (a) 24 1941 (b) [illegible] (Date received by Registrar) (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1941, at 6 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Upper Respiratory Infection
Pulmonary atelectasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Kaylor M.D.
Medical Examiner

Date signed 3-23-41

X

G61548 G61548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 50

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 8-6
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1da. 4hr. 5min.
(e) Length of stay in Baltimore (yrs., mos., or days) 40yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 N. Washington Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Marie Katherine Napfel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Fe.

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Christopher William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan 25 - 1908

8. AGE: Years 40 Months 1 Days 27 If less than one day hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Hwfe.

11. Industry or business

MOTHER / FATHER

12. Name: George W. Meyer

13. Birthplace: Baltimore Md

14. Maiden Name: Emma A. Kenley

15. Birthplace: Baltimore Md

16 (a) Informant: Christopher W. Napfel

(b) Address: 1608 N. Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Wed 28-1948 (month) (day) (year)

(c) Cemetery or crematory: Parkwood Cem

Location: Balto Co. B.M. Walker

18 (a) Funeral director: Pratt & Hughes

(b) Address: 2400 Pennsylvania Ave

19 (a) 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22, 1948, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 21, 1948, to March 22, 1948, and that I last saw her alive on March 22, 1948.

Immediate cause of death: Cardiorespiratory Failure — Duration

Due to: Generalized Carcinomatosis

Due to: Carcinoma Breast

Other Conditions: Jaundice, Ht up ago

(Include pregnancy within 3 months of death)

Date of operation: Oct 1946

Major findings of operation: Ca. Breast

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: John B Wells M. D.

Address: 1 E Lex Bldg Date signed: 3-22-48

VS 150

Dr. Lachmund
4930 Belair Road

G61549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G61549
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5012 Eugene Avenue
(c) Hospital or institution: 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5012 Eugene Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose C. Hofmeister

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife John Hofmeister
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1876

8. AGE: Years	Months	Days	If less than one day
72	-0-	10	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Walter Knox
(b) Address 5012 Eugene Avenue

17 (a) Burial (b) Date thereof 3/25/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

MAR 24 1948 Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22nd 1948 at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1946 to March 22 1948, and that I last saw h[illegible] alive on March 22 1948.

Immediate cause of death	Duration
Generalized Arteriosclerosis	10 years
Due to	
Due to	
Other Conditions Chronic Myocarditis	15 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Lachmund M.D.
Address 4930 Belair Rd Date signed March 24, 1948

G61550

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

54a

Registered No. G61550

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12-4
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No 2103 St. Paul (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ruth Brady
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 4-29-47
8. AGE: Years — | Months 10 | Days — 24 — | If less than one day — hr. — min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Brady
13. Birthplace Texas

MOTHER
14. Maiden name Mary Wilkerson
15. Birthplace So. Car.

16 (a) Informant Mrs. Brady
(b) Address JOHNS HOPKINS HOSPITAL 2103 St. Paul St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 25 48 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Frederick Ave
18 (a) Funeral director John O. Mitchell
(b) Address 1960 Eutaw Place
MAR 24 1948 (Date) by (Huntington Williams M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-23 1948, at 330 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 3-15 1948 to 3-23 1948 and that I last saw h[illegible] alive on 3-23 1948.

Immediate cause of death	Duration
Rhabdomyosarcoma, left frontal	3 mo.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Mar 23, 1948
Major findings of operation: left frontal tumor
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Green M. D.
Address Johns Hopkins Hosp. 601 Broadway Date signed Mar 23 1948

VS 150

G61551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G61551 Registered No. 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 711 Brune St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 Brune St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas T. Harris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible] 1885

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Henrietta Jackson
(b) Address 917 S. Sharp St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-25-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bentley Ave

MAR 24 1948 (Date received) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-21 1948 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 27 1948 to 3-21 1948 and that I last saw h[illegible] alive on March 21 1948

Immediate cause of death: (a) Cardio Vascular Renal
Due to Uremia
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 3-24-48

VS 150

G61552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G61552 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 36 N. Kresson St.
(c) Hospital or institution: 26-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 36 N. Kresson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cora B. Herrick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widow

6 (b) Name of husband or wife George A. Herrick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11-1887

8. AGE: Years	Months	Days	If less than one day
60	5	12	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housework.
11. Industry or business

FATHER
12. Name Dimond
13. Birthplace Not Known

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Walter Herrick
(b) Address 1099 Spangler Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 25-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location E. Donnell St.

18 (a) Funeral director John A. Miller
(b) Address 2534 Jefferson St.

19 (a) MAR 24 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 19 48, at 8:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 48, to March 23 19 48, and that I last saw h e alive on March 23 19 48.

Immediate cause of death Bronchopneumonia — Duration 1 mo.
Due to Chronic Nephritis & Bronchiectasis — Duration ?
Due to
Other Conditions Hypertension Cardiovascular Essential Hypertension — Duration ?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leopard Bull M. D.
Address 1231 N. Eutaw St. Date signed Mar 24 1948

VS 150

106B

G61553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G61553 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hosp. 7-6-6
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3222 E. Jone St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Miller David L.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Edna E. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28-1907

8. AGE: Years	Months	Days	If less than one day
41		26 24	hr. min.

9. Birthplace Pittsburg, Pa. (Town, county and state)
10. Usual Occupation Crane Operator
11. Industry or business

FATHER
12. Name George Miller
13. Birthplace Pa.

MOTHER
14. Maiden Name Lila
15. Birthplace

16 (a) Informant Edna E. Miller
(b) Address 3222 E. Jone St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 26-48 (month) (day) (year)
(c) Cemetery or crematory Dad Lawn
Location Eastern Ave.

18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St.

19 (a) (b) (Signature of Registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1948 at 11 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1948 to Mar 22 1948 and that I last saw him alive on Mar 22 1948.

	Duration
Immediate cause of death Myocardial failure	24 hrs
Due to Paroxysmal auricular flutter	60 hrs
Due to Anterior myocardial infarction, old	2 wks
Other Conditions Cholelithiasis, Pulmonary embolus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Marvin D. Davis M. D.
Address Sinai Hospital Date signed 3-24-48

G61554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

G61554 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va (b) County
(c) City or town Wolf Summit (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laura M. STROUP

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Henry R STROUP
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB 8, 1882

8. AGE: Years 66 | Months 1 | Days 16 | If less than one day hr. min.

9. Birthplace TROUTMAN, Pa (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George R. LUTON
13. Birthplace Pa.

MOTHER
14. Maiden Name Sarah Davidson
15. Birthplace Pa.

16 (a) Informant Mr. Henry R. STROUP - Husband
(b) Address WOLFSUMMIT, W. Va.

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 3/24/48 (month) (day) (year)

(c) Cemetery or crematory
Location CLARKSBURG, W. Va.

18 (a) Funeral director Wm J. TICKNER & SONS
(b) Address BALTIMORE, Md.

19 (a) (Signature of Registrar) (b) Huntington Williams, M.D. Registrar

MAR 24 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-24 1948 at 8:30 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-9 1948 to 3-24 1948, and that I last saw her alive on 3-24 1948

Immediate cause of death	Duration
Cardiac failure	
Due to Possible Pulmonary Thrombosis	
Due to Post op. Pneumonia	
Other Conditions Hysterectomy, Oct 47 Done for carcinoma of Uterus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C B Mearns M. D.
Address Univ Hosp. Date signed 3-24-48

C61555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

111 B

Registered No. C61555

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The street age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1731 Bolton St
(c) Hospital or institution: 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1731 Bolton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah A. McMenamin

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/2/1866

8. AGE: Years 81 | Months 7 | Days 22 | If less than one day hr. min.

9. Birthplace Wash. D.C. (Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER
12. Name Dominick J. McMenamin
13. Birthplace Phil. Pa.

MOTHER
14. Maiden Name Rose A. Kelly
15. Birthplace Phila. Pa.

16 (a) Informant Mrs. Rosemary DeDisenico
(b) Address 1731 Bolton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/48 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Mt. Olivet
Location Wash. D.C.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

19 (a) [illegible] (b) [illegible] (Date received by registrar) Huntington Williams, M.D.

MAR 24 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1948 at 5:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 23 1948 to March 24 1948 and that I last saw her alive on March 24 1948

Immediate cause of death — Duration

Acute Pulmonary Edema

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William G. Stefan M. D.
Address 5006 Roland Av Date signed 3/24/48

VS 150

X

G61556

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

100 B

G61556 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp. 18-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 874 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES BRACEY Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: B | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Corrine

6 (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) June 10, 1919.

8. AGE: Years 28 | Months 9 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace S. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

MOTHER / FATHER

12. Name Charles Bracey.

13. Birthplace S. C.

14. Maiden Name Mary Ramsey

15. Birthplace S. C.

16 (a) Informant Corrine Bracey.

(b) Address 874 W. Fayette St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Mar. 26, 1945. (month) (day) (year)

(c) Cemetery or crematory

Location Sumter S. C.

18 (a) Funeral director Mrs Kate R. Williams

(b) Address 322 N. Schroeder St

MAR 24 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 22, 1945, at 7 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 22, 1945 to Mar 22, 1945, and that I last saw him alive on Mar. 22 at 7-8

Immediate cause of death Cardio-resp. failure -

Due to Probable Pulm. Embolism

Due to Thrombophlebitis

Other Conditions Infection Pneumonia

(Include pregnancy within 3 months of death)

Date of operation 3/2/45

Major findings of operation: Thrombophlebitis left fem. cond. VEIN JAPHENOUS Thrombophlebitis L Saphenous

of autopsy: + Cerebral Edema

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Evan A. Jennings M. D.

Address Univ. Hosp. Date signed 3/22/45

To be approved by Chief Med. Examiner

G61557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G61557

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1431 Ward St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1431 Ward St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Woolford.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1893

8. AGE: Years	Months	Days	If less than one day
54	8	10	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Nathan Woolford
13. Birthplace Md.

MOTHER
14. Maiden Name Sallie Woods
15. Birthplace Baltimore, Md.

16 (a) Informant Elizabeth Woolford.
(b) Address 1431 Ward St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 25, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) MAR 24 1948 (Date received by registrar) (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1948, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 9 1948, to March 21 1948, and that I last saw h.. alive on March 19 48

Immediate cause of death	Duration
Bronchopneumonia	3 Days
Due to Cerebral Thrombosis right	4 days
Due to Arteriosclerotic Cardio Vascular Disease	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julian P. Ulrich, Jr. M.D.
Address 122 N. Wolfe Blvd Date signed 3/22/48

661558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. 661558

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3232 Barclay St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/12 - 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3232 Barclay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ada Williams.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Matthews Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 1, 1889

8. AGE: Years 59 | Months 2 | Days 22 | If less than one day: hr. min.

9. Birthplace Jeansville, Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Hyde
13. Birthplace Virginia

MOTHER
14. Maiden Name Ida L. Hyde
15. Birthplace Virginia

16 (a) Informant Arthur Hyde.
(b) Address 3232 Barclay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 26 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Ambrose
Location

18 (a) Funeral director Mrs. Katie R. William
(b) Address 322 N. Schroeder St.

19 (a) 3/24 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 23, 1948, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 9, 1948 to Mar. 23, 1948. and that I last saw her alive on Feb. 9, 1948.

Immediate cause of death: Carcinoma of Cervix — Duration: unknown

Due to ------

Due to ------

Other Conditions ------

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. W. Morgatroyd M.D.
Address 401 E. 25th. St. Date signed 3/23/48.

VS 150

G61559

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 48a

G61559 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3900 Greenspring Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3900 Greenspring Av. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Olive Baccala

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife: Nick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 25 1905

8. AGE: Years	Months	Days	If less than one day
43		27	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Tailor.
11. Industry or business

FATHER
12. Name Angelo Miserello
13. Birthplace Italy

MOTHER
14. Maiden Name Federick Margaret
15. Birthplace Italy

16 (a) Informant Nick Baccala
(b) Address 3900 Greenspring Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 26 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd

18 (a) Funeral director The Deppel Bros
(b) Address 1800 E Lombard St

19 Date received 1948 (b) by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1948 at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 1947 to March 1948 and that I last saw her alive on March 23 1948.

Immediate cause of death	Duration
Terminal pneumonia Inanition	
Due to Carcinoma of cervix with generalized metastases	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis R. Mason
Address 4335 Park Heights Ave Date signed 3/23/48

VS 150

661560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

661560
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 517 monroe st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 monroe st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Burnett BURNETT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	col.	

6 (b) Name of husband or wife wm Burnett.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/2/1901

8. AGE: Years	Months	Days	If less than one day
47	1	19	hr. min.

9. Birthplace Baltimore md.
(Town, county, and state)

10. Usual Occupation Elevator, Post office

11. Industry or business

FATHER
12. Name Richard King
13. Birthplace va

MOTHER
14. Maiden Name Mary Hall
15. Birthplace Md

16 (a) Informant wm Burnett
(b) Address 511 monroe st

17 (a) Burial (b) Date thereof 3-25-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Druid Hill Ave

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna Ave

19 (a) 3/24/48 (b) Huntington Williamson, M.D.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1948, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1947 to March 21 1948 and that I last saw h[illegible] alive on March 21 1948.

Immediate cause of death	Duration
Coronary Occlusion	
Due to Hypertension	
Arteriosclerosis	
Due to Cerebral Hemorrhage	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M Leahey M. D.
Address 203 N Fremont Date signed

G61561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 139a

G61561 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1432 Marshall St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dora Elizabeth Bennett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife late William Bennett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 | 10 | 1889

8. AGE: Years	Months	Days	If less than one day
58	1	14	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name Ashby McWilliams
13. Birthplace ?

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant S.Bal.General Hospital
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 26/48 (month) (day) (year)
(c) Cemetery [redacted] Lacy Springs Va.
Location [redacted] Harrisonburg Va

18 (a) Funeral director Frank Della Vecchia
(b) Address 52 N. Morley St.

19 (a) Huntington Williams (Date received by registrar) MAR 29 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24/48 19 , at 10 37 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/12 1948 to 3/24 1948, and that I last saw her alive on 3/24 1948.

	Duration
Immediate cause of death Peritonitis Generalized, & Pelvic Abscess	
Due to Mesenteric Thrombosis, Arterial	
Due to Cause undetermined	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Mesenteric Thrombosis of ileum, jejunum
of autopsy Peritonitis & Pelvic abscess

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alex P. Quill, Jr. M.D.
Address South Balto GH Date signed 3/25/48

ALEX P. QUILL, JR.

G61562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. G61562

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 119 E HUGHES ST.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 119 E. HUGHES ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JACOB H. PAUL.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	WIDOWED

6 (b) Name of husband or wife NANCY REED
6 (c) If alive, give age 0 years

7. Birth date of deceased (mo., day, yr.) NOV 11, 1855

8. AGE: Years	Months	Days	If less than one day
92	4	13	hr. min.

9. Birthplace SHAMOKIN, PA (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name JOHN PAUL
13. Birthplace PENNSYLVANIA

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace "

16 (a) Informant MR SAMUEL PAUL
(b) Address 119 E. HUGHES ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3 29 48 (month) (day) (year)
(c) Cemetery or crematory — SHAMOKIN, PENN.
Location SHAMOKIN, PA.

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST.

19 (a) (Date rec'd by registrar) [illegible] WORKS [illegible] DECEASED

VS 193

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24 1948, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1948, to March 24 48 and that I last saw h[illegible] alive on 3/23 1948.

Immediate cause of death	Duration
Cerebral Thrombosis	1 hr
Due to Congestive Heart failure	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 2040 Eutaw Date signed 3/24/48 M. D.

+

Type or print all entries, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G61563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

G61563 Registered No.

Please write clearly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 213 Boulgin St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 213 Boulgin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie M. Zentgraf (Goodwin)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John (Goodwin)

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) June 30, 1879

8. AGE: Years 68 | Months 8 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name August Zentgraf
13. Birthplace Germany

MOTHER
14. Maiden Name Annie
15. Birthplace Germany

16 (a) Informant Mr John (Goodwin)
(b) Address 213 Boulgin St

17 (a) Burial (b) Date thereof 3/26/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Eastern Ave.

18 (a) Funeral director JOHN F. DORNY, INC.
(b) Address 715 Light St.

19 (a) [illegible] A. Washington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22 1948, at 9:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947, to March 22 1948, and that I last saw h[illegible] alive on March 22 1948

Immediate cause of death	Duration
Acute Coronary Failure	1 day
Due to Arteriosclerotic Heart Disease	10 yrs
Due to	
Other Conditions Chronic Arthritis	20 yrs

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — — —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Louis J. Klaus M. D.
Address 526 Linden Ave Date signed

VS 190

× 3 | 72 | 5

G61564

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ G61564 Registered No. 170c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Anne Arundel
(c) City or town Severn (If outside town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte L. KNIGHT

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 18 1944

8. AGE: Years 3 | Months 7 | Days 4 | If less than one day hr. min.

9. Birthplace SEVERN, MD (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name HENRY P. KNIGHT
13. Birthplace SEVERN, MD

MOTHER
14. Maiden Name JUANITA TAYLOR
15. Birthplace SEVERN, MD.

16 (a) Informant: MRS JUANITA T. KNIGHT
(b) Address SEVERN, MD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3 25 48 (month) (day) (year)
(c) Cemetery or crematory MEADOWRIDGE
Location WASHINGTON BLVD.

18 (a) Funeral director JOHN F. DENNY, INC
(b) Address 715 LIGHT ST

19 (a) MAR 24 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-22- 1948, at 1 P. M

21. I certify that I took charge of the remains described above, held an Inspection and Inq. thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: a.a.a.
(a) Date of injury 3/22/48 M.
(b) Where did injury occur? Severn, MD.
(c) Did injury occur at home, on farm, in factory, in public place? Home (Accidently) Was it [illegible]? NO
(d) Means of injury Resp. struggle by hand

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 3/22/48

VS 151

X

G61565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G61565 Registered No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The date of death is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Colvert & Saratoga Sts

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 wks

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 245 East St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mary Travato

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Antonio Travato

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Mar. 10th 1882

8. AGE: Years	Months	Days	If less than one day
66	?0	?14	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Carmello Rocupero

13. Birthplace Italy

MOTHER

14. Maiden Name Caneta ?

15. Birthplace Italy

16 (a) Informant St's Daughter

(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St

MAR 25 1948

MAR 26 1948

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1948 at 2:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 21 1948 to March 27 1948 and that I last saw her alive on March 23 1948.

Immediate cause of death	Duration
Coronary infarction	
Due to Hypertensive C-V	
Due to Disease.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature L M Jernigan

Address Mercy Hospital Date signed 3/27/48

VS 150

X

G61566

BC-69724

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

G61566
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT ST
(c) Hospital or institution:
MERCY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 DAY
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1171 W. HAMBURG ST.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE LEO HARTLOVE, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age 19 years

7. Birth date of deceased (mo., day, yr.) DEC 24, 1948

8. AGE: Years	Months	Days	If less than one day
	3	29	hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name GEORGE L. HARTLOVE, Sr.
13. Birthplace BALTIMORE

MOTHER
14. Maiden Name BARBARA ZERRLAUT
15. Birthplace BALTIMORE

16 (a) Informant ADM. SLIP
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-25-48 (month) (day) (year)
(c) Cemetery or crematory Dulaney Hollow
Location Pikesville Highway

18 (a) Funeral director Joseph S. Ambrose Jr.
(b) Address 414 E. Franklintown Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 25 1948
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23/48 19 , at 1 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/22 1948 to 3/23 1948
and that I last saw h.i.M alive on 3/22 1948

Immediate cause of death MALNUTRITION, DEHYDRATION — Duration

Due to PREMATURITY

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elden H. Pertz M. D.
Address Mercy Hosp Date signed 3/23/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Ad 61567 3

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

661567 Registered No. new

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 918 N. Caroline St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Housemaid
11. Industry or business

FATHER
12. Name Frank Carroll
13. Birthplace Va

MOTHER
14. Maiden Name Elizabeth Coleman
15. Birthplace Va

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Joseph B. Locks Jr
(b) Address 1304 W. Central Ave

MAR 25 1948 (a) Date received by registrar (b) Wintington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23 1948, at 1 10 A M

21. I certify that death occurred on the date above stated: that I attended deceased from 3/22 1948 to 3/23 1948
and that I last saw her alive on 3/23 1948

Immediate cause of death	Duration
Resp. Coma	
Due to Cerebral hemorrhage	
Due to HCVD	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Dusak
Address 5 H N Date signed 3-23-48

X

G61568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G61568 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 31
(d) Length of stay in hospital or inst. (yrs., mos., or days): 6 days
(e) Length of stay in Baltimore (yrs., mos., or days): 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 1812 E. Lombard St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: THOMAS JEFFERSON SLAUGHTER

3 (b) If veteran, name war: WW I ?

3 (c) Social Security Account No.: 217-50-6587

4. Sex: M

5. Color or race: col

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 20, 1895

8. AGE: Years: 52 | Months: 6 | Days: 8 | If less than one day: hr. min.

9. Birthplace: York Co. Va.
(Town, county, and state)

10. Usual Occupation: laborer

11. Industry or business

FATHER
12. Name: Thomas Slaughter
13. Birthplace: York Co. Va.

MOTHER
14. Maiden Name: Elizabeth Waller
15 Birthplace: York Co. Va.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/48 (month) (day) (year)
(c) Cemetery or crematory: Balt. National
Location: 5501 Frederick Ave

18 (a) Funeral director: Joseph S. Lock, Jr.
(b) Address: 1304 N. Central Ave

19 (a) MAR 5 1948 (Date received) (b) (Registrar)
Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 23 1948, at 2 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 17 1948 to Mar. 23 1948, and that I last saw him alive on Mar. 23 1948.

Immediate cause of death: 1- Nephritis, subacute with uremia — Duration: Unknown
Due to: 2- Cardiac hypertrophy with congestive failure — 3 mos.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: J. F. van Ackeren, Medical Director
Address: Medical Officer in Charge signed: 3/24/48

X

G61569
JL - 15670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G61569
Registered No. 128

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 54
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 N. Exter St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Horace Colton or Horace Coulter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1879

8. AGE: Years	Months	Days	If less than one day
68	6	11	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Moses
13. Birthplace

MOTHER
14. Maiden Name Margaret Cummins
15 Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3/25/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County, Md.

18 (a) Funeral director Joseph L. Locke
(b) Address 1364 N. Central Ave

19 (a) MAR 26 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1948, at 4.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 8, 1931, to March 18 1948, and that I last saw him alive on March 18 1948.

Immediate cause of death	Duration
Fibrocaseous Tuberculosis left upper lobe of Lung	?
Due to Tuberculous Peritonitis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Laurence Lee Jr. M. D.
Address Baltimore City Hosp Date signed 3-27-48

VS 150

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

661570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 661570

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard and Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Randallstown,
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Bell Gaither

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lillian Thornberg Gaither
6 (c) If alive, give age 189 years

7. Birth date of deceased (mo., day, yr.) March 26, ~~1880~~

8. AGE: Years	Months	Days	If less than one day
56 ~~57~~	11 ~~3~~	26	hr. min.

9. Birthplace Howard County, Md.
(Town, county, and state)
10. Usual Occupation Retired Builder
11. Industry or business Self

FATHER
12. Name Henry Clay Gaither
13. Birthplace Howard County, Md.

MOTHER
14. Maiden Name Abbey Cavey
15. Birthplace Howard County, Md.

16 (a) Informant Mrs. Henry C. Gaither
(b) Address 47 Nunnery Lane, Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 25, 1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18 (a) Funeral director Miles Funeral Home
(b) Address 4510 Liberty Heights Ave.

MAR 25 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1948, at 10.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 21 1948 to Mar 22 1948 and that I last saw him alive on Mar 22 1948

Immediate cause of death	Duration
Coronary Thrombosis	2 days
Due to Angina Pectoris	10 years
Due to	
Other Conditions Arteriosclerosis, Cholelithiasis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. C. Gaither M. D.
Address 4509 Liberty HgtsAve Date signed

VS 150

G61571

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G61571
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 426 S. Patterson Park Ave.
(c) Hospital or institution: - - - None - - -
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 40 Waterview Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country - - - -

3 (a) FULL NAME ROBERT E. LEE WILEY

3 (b) If veteran, name war	3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife - None -
6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) October 15, 1870

8. AGE: Years	Months	Days	If less than one day
77	5	7	....hr. ....min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name William Wiley
13. Birthplace Baltimore

MOTHER
14. Maiden Name Louisa Files
15. Birthplace Germany

16 (a) Informant Mary M. Taylor
(b) Address 426 S. Patterson Park Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/1948 (month) (day) (year)
(c) Cemetery or crematory Mount Carmel Cemetery
Location O'Donnell St. Baltimore, Md.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 1901 Eastern Avenue, Balto. 31

19 MAR 25 1948 (Date rec'd by registrar) (b) Tuttington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22, 1948, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-8-48 19.... to Mar. 22 1948, and that I last saw h.m. alive on Mar 22 19 48

Immediate cause of death	Duration
Cardio - vascular arteriosclerosis	years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ....at ....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sigmund R. Nowak M.D.
Address 408 S. Patt. Pk. Ave. Date signed 3/23/48 M. D.

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G61572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G61572

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2838 Riggs Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10

(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2838 Riggs Ave (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mary E. O'Rourke

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Patrick J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 18th 1873

8. AGE: Years 74 | Months 5 | Days 5 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business at Home

FATHER

12. Name John O'Connor

13. Birthplace Ireland

MOTHER

14. Maiden Name Catherine Enright

15. Birthplace Ireland

16 (a) Informant Mrs. Mary E. Ireland

(b) Address 2838 Riggs Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/48 (month) (day) (year)

(c) Cemetery or crematory New Estheldal Cemetery

Location 4200 Old Frederick Rd

18 (a) Funeral director John J. Cowan & Son

(b) Address 701-03 Hollins St.

19 Mar 25 1948 (Date rec'd) (By) Registrar Wilmington, Del.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 23rd 1948, at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-10 1948 to 3/23 1948.

and that I last saw her alive on 3/22/48.

Immediate cause of death

Acute Cardiac Failure — Duration 1 da

Due to

Hemorrhoid Atherosclerosis — 5 yr

Due to Arteriosclerotic Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Dr. Hugh F. Lawlor M. D.

Address 6 Wrightington Rd Date signed 3/24/48

VS 150

661573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 661573

467

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (~~yrs. mos. or~~ days) 25
(e) Length of stay in Baltimore (~~yrs. mos. or~~ days) 25

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster, Rt. #2 (If outside city or town limits, write RURAL and give town)
(d) Street No. Near Union Mills Md. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Ira R. Englar

3 (b) If veteran, name war None | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) ~~Single~~ married, ~~widowed or divorced~~.

6 (b) Name of husband or wife Eloise Englar
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1877

8. AGE: Years 70 | Months 6 | Days 17 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Mr. William Englar
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Elizabeth Cassell
15 Birthplace Maryland

16 (a) Informant Mrs. Ira Englar
(b) Address Westminster Md. R.D. #2

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Meadow Branch
Location Near Westminster Md.

18 (a) Funeral director J. S. Myers & Sons
(b) Address Westminster Md.

MAR 25 1948 (Date rec'd by registrar) Temperance Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1948, at 8:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 29 1948, to March 29 1948, and that I last saw him alive on March 29 1948.

Immediate cause of death Pulmonary Embolism — Duration

Due to Post operation Care of rectum

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3-9-48

Major findings of operation: Carcinoma of Rectum

of autopsy: Post Mortem

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. W. Johnson M.D.
Address Union Memorial Hosp Date signed 24 Mar 48

VS 159

G61574

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G61574
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 607 Reservoir Street.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County Stafford.
(c) City or town Widewater (Rural)
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Thomas Dorsey.

3 (b) If veteran, name war X

3 (c) Social Security Account No. X

4. Sex Fem. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1873

8. AGE: Years 75 | Months 1 | Days 5 | If less than one day hr. min.

9. Birthplace Glenwood, Howard Co., Md.
(Town, county, and state)

10. Usual Occupation Companion.

11. Industry or business

MOTHER / FATHER

12. Name William Thomas Dorsey.

13. Birthplace Glenwood, Md.

MOTHER

14. Maiden Name Elizabeth Snowden

15. Birthplace Glenwood, Md.

16 (a) Informant William S Dorsey

(b) Address 607 Reservoir Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/48 (month) (day) (year)

(c) Cemetery or crematory Oak Grove Cemy.
Location Howard Co. Md.

18 (a) Funeral director John O. Mitchell & Sons

(b) Address 1900 Eutaw St.

19 (a) 5 1948 (Date received by registrar) (b) Washington Nathanson, Registrar

MAR

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1948 at 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from January 1948 to March 25 1948, and that I last saw her alive on Mar. 25 1948.

Immediate cause of death: Arteriosclerotic heart disease
~~Diabetes~~ — Duration: 6 months.

Due to

Due to

Other Conditions Diabetes mellitus.
(Include pregnancy within 3 months of death)

Date of operation None.

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature John A. Luetscher, Jr. M. D.

Address 1916 Winston Ave. Date signed 3/25/48.

937

G61575 ✓ G61575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1949 W. FAYETTE ST.
(c) Hospital or institution: —
W
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 65 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1949 W. FAYETTE ST.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) FULL NAME Miss EVA ALDRIDGE

3 (b) If veteran, name war —

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) DEC. 10, 1882

8. AGE: Years	Months	Days	If less than one day
65	3	12	— hr. — min.

9. Birthplace BALTIMORE.
(Town, county, and state)
10. Usual Occupation POLICEWOMAN (RETIRED)
11. Industry or business BALTO. POLICE DEPT

FATHER
12. Name JOHN W. ALDRIDGE.
13. Birthplace HOWARD Co., Md.

MOTHER
14. Maiden Name ELIZABETH A. MERCER
15. Birthplace BALTIMORE, Md.

16 (a) Informant MRS. ALBERT E. ALDRIDGE
(b) Address 3040 W. NORTH AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 25, 1948 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK CEM.
Location FREDK. AVENUE.

18 (a) Funeral director Walter Bowen Bradley
(b) Address 1922 W. North Avenue

19 (a) — (Date rec'd by registrar) (b) — Registrar

MAR 25 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-22-1948, at 1 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1947 to March 22 1948 and that I last saw her alive on 3-20 1948

Immediate cause of death Carcinomatosis — Duration Un Known

Due to Carcinoma of the Pancreas — Duration Un known

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation January 1948

Major findings of operation: Carcinoma of pancreas with wide spread abdominal metastasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature H. E. Sumwalt M.D.
M. D.
Address 1100 St Paul St Date signed 3-22-48

X

G61576

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G61576 ✓ 937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3605 Hillsdale Rd.
(c) Hospital or institution: Anderson Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 7 —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3700 Menlo Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry C. Tiemeyer Sr.

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife: Emelie F. Tiemeyer Nee Raider
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1860

8. AGE: Years	Months	Days	If less than one day
87	10	9	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Charles Tiemeyer
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown Christina
15. Birthplace Germany

16 (a) Informant Mr. Charles H. Tiemeyer (Son)
(b) Address 5211 Norwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Baltimore, Md.

19 (a) (Date received by registrar) (b) Registrar

MAR 25 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-1940 to 3-24-1948 and that I last saw him alive on 3-24-1948

Immediate cause of death	Duration
Myocardial failure (Chr.)	6 mos.
Due to Arteriosclerosis	—
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry H. Warner M. D.
Address 2604 Garrison Blvd Date signed 3-25-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C61577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH. 13B

C61577 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3122 BERKSHIRE RD
(c) Hospital or institution:
(d) Length of stay in hospital or institution (yrs., mos., or days) ABOVE ADDRESS or days 17 YRS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3122 BERKSHIRE RD (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MELVIN LEROY MORITZ

MEDICAL CERTIFICATION

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 7, 1898

8. AGE: Years	Months	Days	If less than one day
49	5 4	16	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation SCHOOL TEACHER (RETIRED)
11. Industry or business BALTO. CITY

FATHER
12. Name ALBERT MORITZ
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name MARY M. GERNAND
15. Birthplace BALTO. MD.

16 (a) Informant MRS. MINNIE WITTIG
(b) Address 3122 BERKSHIRE RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/27/48 (month) (day) (year)
(c) Cemetery or crematory PARKWOOD CEM.
Location BALTO. CO. MD.

18 (a) Funeral director WM. J. TICHLER & SONS
(b) Address BALTO. (Wilkens Ave.) MD.

19 (a) 1948 (Date rec'd by registrar) (b) Registrar

20. DATE OF DEATH March 23 1948, at 7.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 23 1948 to March 23 1948 and that I last saw him alive on March 23 1948.

Immediate cause of death	Duration
Tuberculosis Pulmonary	3-4 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
Date of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 9655 Harford Rd Date signed 3/24/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information asked for on this certificate should be carefully supplied. The

G61578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127a

G61578 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 532 Wyanoke Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 532 WYANOKE Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Stella Cole

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced WIDOWED

6 (b) Name of husband or wife Wm. B. Cole

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB 7, 1858

8. AGE: Years 90 | Months 1 | Days 17 | If less than one day hr. min.

9. Birthplace BALTO. CO., MD (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business —

FATHER

12. Name JOSEPH FORRESTER

13. Birthplace BALTO. CO., MD.

MOTHER

14. Maiden Name ELIZABETH BIDDISON

15. Birthplace BALTO. CO. MD.

16 (a) Informant MR. ROBERT McGINN

(b) Address 5201 TRANORE AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/26/48 (month) (day) (year)

(c) Cemetery or crematory LORDAN PK.

Location BALTIMORE, MD.

18 (a) Funeral director WM J. TICKNER & SONS

(b) Address BALTO., MD.

19 (a) (Date rec'd by registrar) (b) Transit or Burial Permit No.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 24 1948, at 2.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948, to Mar 24 1948, and that I last saw h.e.r. alive on Mar 23 1948.

Immediate cause of death	Duration
Abscess (Empyema)	6 days?
of Gall Bladder	
Due to Chr. Cholecystitis	2 yrs +
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature F. V. D. Mack M.D.

Address 513 E. 39th St. Date signed 3/24/48

VS 150

X

661579 661579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5708 BELLONA Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5708 BELLONA Ave
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME JOHN N. GOTH

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NO

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	WIDOWED

6 (b) Name of husband or wife ALICE C. GOTH
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR. 9, 1883

8. AGE: Years	Months	Days	If less than one day
64	11	15	hr. min.

9. Birthplace BALTO., MD.
(Town, county, and state)
10. Usual Occupation DENTAL LABORATORY
11. Industry or business SELF

FATHER
12. Name JOSEPH GOTH
13. Birthplace AUSTRIA

MOTHER
14. Maiden Name JOSEPHINE KENNEL
15 Birthplace AUSTRIA

16 (a) Informant MR. CHARLES GOTH - (BROTHER)
(b) Address 5708 BELLONA AVE

17 (a) BURIAL (b) Date thereof 3/27/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON PK.
Location BALTO., MD.

18 (a) Funeral director WM J. TICKNER & SON
(b) Address BALTO MD.

19 (a) MAR 25 1948 (b) Hunting Town, Williams, MD
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 MARCH 1948, at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 19, 1947, to Mar 24 1948, and that I last saw him alive on 23 MAR 1948.

Immediate cause of death	Duration
Coronary Thrombosis	15 MIN.
Due to Chronic Myocarditis	2 YRS.
Due to	
Other Conditions Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Lloyd E. Taylor M. D.
Address 3902 Greenmount Ave Date signed Mar. 24 48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G61580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G61580

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2704 E. Chase St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2704 E. Chase St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CONRAD MAURER

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-5667

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ida B. Maurer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1886.

8. AGE: Years	Months	Days	If less than one day
61	2	24	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business Tin Decorating Co.

MOTHER / FATHER

12. Name Conrad Maurer

13. Birthplace Germany

14. Maiden Name Theresa ?

15 Birthplace Germany

16 (a) Informant Ida B Maurer (Widow)

(b) Address 2704 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-27-48. (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem.

Location 4430 Belair Rd.

18 (a) Funeral director Charles E. Zeiler.

(b) Address 901 S. Conkling St.

19 (a) MAR 27 1948 (Date received by registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1948, at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-19 1948, to 3-23 1948; and that I last saw h[illegible] alive on 3-23 1948.

Immediate cause of death Coronary occlusion

Duration 3 days

Due to Arteriosclerosis & myocardial deg. 4 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.

Address 5401 Belair Rd. Date signed 3-27-48.

G61581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1108

G61581 Registered No.

The entries on this certificate should be typewritten or printed with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline Street
(c) Hospital or institution: St Josephs Hosp 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs.) mos., or days) 10

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2442 Francis St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edith Ophelia Sullivan

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-12-1026

4. Sex Female

5. Color or race Black

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband ~~or wife~~ Henry Sullivan

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years 38 | Months — | Days — | If less than one day hr. min.

9. Birthplace Grasonville, Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Louis C. Thomas
13. Birthplace Grasonville, Md

MOTHER
14. Maiden Name Ophelia Griffin
15. Birthplace Calmichael, Md.

16 (a) Informant Mrs. Ophelia Blackston
(b) Address Route 1 Box 2 Grasonville, Md

17 (a) Burial (b) Date thereof 3-27-48
(burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Bryans M.E. Church
Location Grasonville, Md

18 (a) Funeral director Mrs. Geo. H. Wollard
(b) Address 1631 Druid Hill Ave.

MAR 26 1948 (Date) by registrar (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23/48 19..., at 6 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/21/48 19... to 3/23/48.
and that I last saw h.e alive on 3/23/48

Immediate cause of death	Duration
Lobular pneumonia	
Pulmonary Edema	
Due to Chronic Glomerulo nephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: pneumonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter Bailey M.D.
Address St Joseph's Date signed 3/23/48

VS 150

G61582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G61582

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3521 Reisterstown Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3521 Reisterstown Rd. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA M. BAUM.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Louis Baum
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1881.

8. AGE: Years	Months	Days	If less than one day
67	2	11	hr. min.

9. Birthplace Littlestown, Md. (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name ? Stauffer.
13. Birthplace Unknown.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Unknown.

16 (a) Informant Mr. Louis Baum.
(b) Address 3521 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3.25.48. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Baltimore, Md.

18 (a) Funeral director [illegible]
(b) Address 1902 Eutaw Place.

19 (a) MAR 25 1948 (Date rec'd by Registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23. 1948 at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1946 to March 23 1948
and that I last saw h[illegible] alive on Mar 23 1948

Immediate cause of death Acute Congestive Failure — Duration
Due to Hypertensive CVD
Due to
Other Conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lorland Applefeld M. D.
Address 2511 Reisterstown Rd. Date signed

VS 150

[illegible] 937

G61583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G61583

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 21 E. West St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 21 E. West St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Franklin B. Staylor

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary J. Staylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 28 - 1886

8. AGE: Years	Months	Days	If less than one day
61 62	11	5 2	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business City

FATHER

12. Name Sylvester Staylor

13. Birthplace Baltimore Md.

MOTHER

14. Maiden Name Louise Beaker

15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Mary J. Staylor

(b) Address 21 E. West St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 26 - 48 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Holy Cross

Location Ritchie Highway G.A.Co.

18 (a) Funeral director Elizabeth Starke Fun.

(b) Address 115 E. West St.

19 (a) MAR 25 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 28th 1948, at 6:7 M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1st 1948, to Mar 27 1948, and that I last saw h[illegible] alive on Mar 27 1948.

Immediate cause of death	Duration
Coronary thrombosis	15 Min
Due to Cardiac Failure	3 Hrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. F. Holy Rosa

Address 10 Randall St. Date signed 3/26/48

VS 150

X

G61584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

G61584 Registered No.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2434 Frederick Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2434 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Johanna Cooney

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Thomas V. Cooney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1867

8. AGE: Years	Months	Days	If less than one day
81	1	8	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Kelleher
13. Birthplace Ireland

MOTHER
14. Maiden Name ?
15. Birthplace Ireland

16 (a) Informant Thomas Cooney
(b) Address 810 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 27, 1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St

19 (a) Mar 26 1948 (Date received by Registrar) Huntington Williams M.D. Registrar

MAR 1933 N Bolton St

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25/48, 1948, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1948, to March 23 1948, and that I last saw her alive on March 21 1948.

Immediate cause of death	Duration
Congestive Heart Failure	5 days.
Due to Arterio Sclerosis & Myocardial Weakness.	10 yrs
Due to Cerebral Hemorrhage & Facial Hemiplegia	2 yrs
Other Conditions Anemia, Malnutrition	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. Antz Jr. M. D.
Address 1433 N Bolton St Date signed 3/24/48

X

G61585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G61585 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St.
(c) Hospital or institution: Home for the Aged
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ellen Schultheis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	W.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19 1876

8. AGE: Years	Months	Days	If less than one day
71	7	4	hr. min.

9. Birthplace Charles Co Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Stephen Burch
13. Birthplace

MOTHER 14. Maiden Name Martha Welch
15. Birthplace

16 (a) Informant Mrs. Louise Parker 1200 Valley St.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 26 1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 E. Biddle St

MAR 25 1948 (a) (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1948, at 1 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 1 1948 to Mch 23 1948. and that I last saw her alive on Mch 22 1948.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic Myocarditis	5 yr.
Due to	
Other Conditions Arterio Sclerosis	10 yr.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. Northern Ave Date signed 3/25/48

Huntington Williams, Mdl

X

EL 117956
G61586

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ 112

Registered No. G61586

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 310 Wheeler Court Turner Sta.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dave Mack

3 (b) If veteran, name war

3 (c) Social Security Account No. 156-09-3459

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Colored	Married

6 (b) Name of husband or wife Roxie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1897

8. AGE: Years	Months	Days	If less than one day
51	2	9	hr. min.

9. Birthplace South Carolina
(Town, county, and state)
10. Usual Occupation Janitor--Farmer
11. Industry or business

FATHER
12. Name Henry Mack
13. Birthplace South Carolina

MOTHER
14. Maiden Name Minnie Jackson
15. Birthplace South Carolina

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-27-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location
18 (a) Funeral director Undertaking Co. Edward Hillard
(b) Address 918 Lexington Williams Mgr.
19 (a) MAR 25 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1948, at 5-15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 6 1948, to March 23 1948 and that I last saw him alive on March 23 1948.

Immediate cause of death	Duration
Atelectasis of left lung postoperative (2° pneumonia)	24 hrs.
Due to	
Due to	
Other Conditions Bullous Emphysema of lung; asthma	

(Include pregnancy within 3 months of death)

Date of operation 3-22-48
Major findings of operation: Bullous Emphysema of right lung
of autopsy: Abdomen

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice M. Lacy, M.D.
M. D.
Address Baltimore City Hosp. Date signed 7-24-48

VS 150

X

661587

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a ✓ Registered No. 661587

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23 East Cross St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 23 East Cross St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rozele Mary Berman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Max

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER
12. Name Harry
13. Birthplace Russia

MOTHER
14. Maiden Name Esther
15. Birthplace Russia

16 (a) Informant Harry Berman
(b) Address 23 E Cross St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-26-48 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Boulevard

18 (a) Funeral director Jack Lewis Inc
(b) Address 2160 Eutaw Place

MAR 25 1948 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-24 1948, at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 29 1947 to MAR 24 1948 and that I last saw her alive on MAR 24 1948

Immediate cause of death: CEREBRAL THROMBOSIS — Duration: 1 HOUR

Due to: ARTERIO SCLEROSIS

Due to:

Other Conditions: HYPERTENSION

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stuart D. Judy M.D.
Address 201 E. 33rd St. Date signed 3/25/48

VS 130

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G61588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G61588

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1017 MAHDIES ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No 1017 MAHDIES ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES W HOBECK. SR

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-01-1259

4. Sex MALE | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife JENNIE HOBECK

6 (c) If alive, give age 2 years

7. Birth date of deceased (mo., day, yr.) FEB 13-1892

8. AGE: Years 56 | Months 1 | Days 17 | If less than one day ..... hr. ..... min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business

FATHER
12. Name CHAS HOBECK.
13. Birthplace BALTO MD

MOTHER
14. Maiden Name BLANCH. BLONDELL
15. Birthplace FRANCE

16 (a) Informant JENNIE HOBECK
(b) Address 1017 MAHDIES ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-27-48 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location A.A.Co

18 (a) Funeral director Bernard C Hahn
(b) Address 121 E West St

MAR 25 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 24 1948, at 1245 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11 1948 to 3-24- 1948, and that I last saw him alive on 3/23 1948.

Immediate cause of death	Duration
(a) Pulmonary Edema	
Due to Hypertensive Arterio Sclerosis	
Due to	
Other Conditions Impaired Diabetes	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E Tetrault M. D.
Address 2155 Valley Ave Date signed 3/24/1948

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G61589

BALTIMORE CITY HEALTH DEPARTMENT ✓ G61589 Registered No.

CERTIFICATE OF DEATH. 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2109 RAMSAY ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 - 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 RAMSAY. ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH V WEINRICH.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex FEM

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife WILLIAM H WEINRICH

6 (c) If alive, give age 7, years

7. Birth date of deceased (mo., day, yr.) JAN 13-1907

8. AGE: Years 41 | Months 2 | Days 11 | If less than one day ..... hr. ..... min.

9. Birthplace MARYLAND. (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER 12. Name CLYDE R THOMPSON

13. Birthplace MARYLAND

MOTHER 14. Maiden Name MARY. PILKERTON

15 Birthplace MARYLAND

16 (a) Informant WILLIAM. H. WEINRICH.

(b) Address 2109 RAMSAY. ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-27-4 (month) (day) (year)

(c) Cemetery or crematory LOUDON PARK.

Location FREDERICK. RD.

18 (a) Funeral director Bernard C Hahn

(b) Address 121 E West St

19 (a) Worthington Williams, M.D. (Date received by registrar) Registrar

MAR 25 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 24 1948, at 5.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 1 1946 to 3/24 1948. and that I last saw h.. alive on 3/24 1948.

Immediate cause of death Pulmonary Tuberculosis (active) — Duration 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M.D.

Address Date signed 3/27/48

X

The Registrar will not accept certificates written in PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G61590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

G61590 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette St
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days) 2 da 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 127 Mc. Phail St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME John Overwetter

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-3972

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1st 1902

8. AGE: Years	Months	Days	If less than one day
46	7	21	— hr. — min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business Chas. Kleinert & Co

MOTHER / FATHER

12. Name Fred. Overwetter

13. Birthplace Maryland

14. Maiden Name Elizabeth Howard

15. Birthplace Maryland

16 (a) Informant Miss. Elizabeth Landwehr

(b) Address 235 Frederick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 26 Mar 48 (month) (day) (year)

(c) Cemetery or crematory Western Cemetery Location Baltimore City

18 (a) Funeral director J. Bl Wiskert & Son

(b) Address 1300 Eutaw Place

19 (a) MAR 25 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1948, at 11 55 P M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 20/4

(a) Date of injury 3-22-48 at 10:00 P M

(b) Where did injury occur? Balto. Paint Color Work factory 15 S. Calvert St

(c) Did injury occur at home, on farm, industrial place, Republic place? Public While at work? no

(d) Means of injury Fell from Floor - Wall collapsed on him

23. Signature [signature] M.D. Medical Examiner.

Date signed 3-22-48

X

correct are is especially important. Physicians: please write the causes of death clearly and legibly.

G61591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92E

G61591 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2345 Laurella Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2345 Laurella Ave (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Louis F. Snyder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife Lucy Snyder
6 (c) If alive, give age 5 years

7. Birth date of deceased (mo., day, yr.) 10/12/1868

8. AGE: Years	Months	Days	If less than one day
79	5	7 10	hr. min.

9. Birthplace Port Deposit Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Snyder
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Geo. Harris
(b) Address 2345 Laurella Ave.

17 (a) Burial (b) Date thereof 25 March
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore City

18 (a) Funeral director L. Hilbert & Son
(b) Address 800 Eutaw Place

19 (a) MAR 25 1948 (b) Huntington W.Va. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22/1948 19 at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/8/48 19 to 3/22/48 19, and that I last saw h. alive on 3/22/48 19

Immediate cause of death	Duration
(a) Endocarditis	months
Due to (b) Septicemia	"
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Palmer A. Gosson M.D.
Address 1012 Eschange Pl. Date signed 3/24/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

661592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. 661592

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 558 Robert St
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2m 14
(e) Length of stay in Baltimore (yrs., mos., or days) 31y

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 558 Robert St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Brown
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
48 47			hr. min.

9. Birthplace Accomack Co., Va
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Geo. V. Tunnery
13. Birthplace Va.

MOTHER
14. Maiden Name Betty Ames
15. Birthplace Va.

16 (a) Informant Robert Brown
(b) Address 558 Robert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 24 1948 (month) (day) (year)
(c) Cemetery or crematory Antioch
Location Baltimore Md.

18 (a) Funeral director Geo. H. Pelson
(b) Address 803 Pennsylvania Ave

19 (a) 5 1948 (Date received by registrar) (b) Courtney Jefferson Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1948 at 4:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from February 1947 to March 1948
and that I last saw h[illegible] alive on March 23 1948.

Immediate cause of death	Duration
Ca. of Cervix Uteri	
Due to Metastasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maynard W. Jones M. D.
Address 300 N. Charles St Date signed 3/25/48

VS 150

G61593

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G61593

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1710 E. Lafayette ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 12 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 E. Lafayette ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James M. Gruver (James M. Gruver)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ida Farner
6 (c) If alive, give age (D) years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1858

8. AGE: Years 89 | Months 5 | Days 27 | If less than one day ######## min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation Retired
11. Industry or business Farm work

MOTHER / FATHER

12. Name ? Gruver
13. Birthplace Pennsylvania
14. Maiden Name ? Black
15. Birthplace Pennsylvania

16 (a) Informant Mr. Charles M. Gruver (Son)
(b) Address 1710 E. Lafayette Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/48 (month) (day) (year)
(c) Cemetery or crematory Spring Hill Cemetery
Location Shippensburg, Pennsylvania

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) [illegible] (b) Huntington Williams, M.D. Registrar
(Registrar)

MAR 25 1948

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-24-1948 at 10 A M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. F. Zubinski MD for G. G. Merrill MD
Medical Examiner.
Date signed 3/24/48

X

G61594

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

181

G61594
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp. 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1729 Asquith Ste.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lloyd N. LANHAM

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-2496

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Margaret A. Lanham
6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) Oct. 13 - 1917

8. AGE: Years	Months	Days	If less than one day
33	5	11	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Welder
11. Industry or business Bath. Steel Sparrows Pt.

FATHER
12. Name John J. Lanham
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Es. Dowell
15. Birthplace Md.

16 (a) Informant Margaret A. Lanham
(b) Address 1729 Asquith St.

17 (a) Burial (b) Date thereof 3-27-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location North Rye.

18 (a) Funeral director John C. Miller Jr.
(b) Address 2435 E. Oliver St.

19 (a) MAR 25 1948 (b) Arlington Baltimore, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1948, at 7 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Toxemia from infected burns of face, head, hands, and arms
Due to Fractured left ribs
Atelectasis left lung
Other Conditions Amputation right leg.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-16-48 at 11:30 A M.
(b) Where did injury occur? Bethlehem Steel Corp. Sparrows Pt.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? yes
(d) Means of injury Fell into barrel of Acetar

23. Signature Chas. G. Merrill M.D.
Medical Examiner.
Date signed 3/24/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 181

G61595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G61595 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6124 Belair Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas L. Wallace

3 (b) If veteran, name war: none
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Amelia Wallace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 19, 1895

8. AGE: Years 52 | Months 5 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore - Md (Town, county, and state)

10. Usual Occupation Order Clerk

11. Industry or business

FATHER
12. Name Edward J. Wallace
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Anna McShane
15 Birthplace Baltimore, Md.

16 (a) Informant Mrs. Amelia Wallace
(b) Address 6124 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Park
Location Taylor ave

18 (a) Funeral director Howard N. Blight Jr
(b) Address 4914 Belair Road

MAR 25 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24 1948, at 10:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/22 1948 to 3/24 1948 and that I last saw him alive on 3/24 1948.

Immediate cause of death	Duration
Cerebral thrombosis	
Due to	
Due to	
Other Conditions: Hypertension with Chronic Nephritis Diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Basilar artery Thrombosis

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herman M. Mann M. D.
Address Sinai Hosp Date signed 3/25/48

Tentative for Williams MD / John R. Davis MD / per 83-5 H. Merrill MD

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G61596 Ad 1

BALTIMORE CITY HEALTH DEPARTMENT X V

CERTIFICATE OF DEATH

124 B

G61596

Registered No. 408123

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Johnstown (If outside city or town limits, write RURAL and give town)
(d) Street No. 756 Park Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Tecora

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Robert Tecora
6 (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) 8/13/1917

8. AGE: Years	Months	Days	If less than one day
28	7	12	hr. min.

9. Birthplace Penn. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Ignatius Mutter
13. Birthplace Germany

MOTHER
14. Maiden Name Therese Xenulinger
15. Birthplace Germany

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof March 25 (month) (day) (year)
(c) Cemetery or crematory Grand View Cem
Location Johnstown Pa

18 (a) Funeral director Ullrich Funeral Home
(b) Address 200 S Orleans St

19 MAR 26 1948 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25 1948, at 2 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/12 1948 to 3/25 1948, and that I last saw her alive on 3/25 1948.

Immediate cause of death Cirrhosis of the liver — Duration 2½ yrs

Due to ? infectious hepatitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Victor A. McKusick M.D.
Address Johns Hopkins Hosp Date signed 3/25

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G61597 #44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1579

G61597

Registered No. 61487

The entries on this certificate, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Petersburg (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Norma Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/3/48

8. AGE: Years	Months	Days	If less than one day
		22	hr. min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Overton Hall.
13. Birthplace Monty, Co. W Va

MOTHER
14. Maiden Name Minnie Babe Hall.
15. Birthplace Wardfield. W Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/48 (month) (day) (year)
(c) Cemetery or crematory [illegible] W Va.
Location [illegible]

18 (a) Funeral director John O Mitchell Sons.
(b) Address 900 Eutaw Place

19 (a) MAR 26 1948 (Date rec'd by registrar) Huntington, W. Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25 1948, at 7:00 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17 1948, to 3/25 1948, and that I last saw her alive on 3/25 1948.

Immediate cause of death Pneumonia + Atelectasis — Duration Life

Due to Postoperative —

Due to Hi Diaphragmatic Hernia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3/20/48

Major findings of operation Hi bagging Hernia + splean + small bowel in sac

of autopsy

PHYSICIAN Underline the one to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 3/31/48

VS 150

661598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

Registered No. 661598

Physicians: please write the causes of death clearly and legibly. The correct age is especially important. Please give street address or location, whether in city or country.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1014 Rosedale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 Rosedale St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Andrew W. Lunger

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NO

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Williamsport, Pa. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Lunger
13. Birthplace Williamsport Pa.

MOTHER
14. Maiden Name Mary Krug
15. Birthplace Williamsport Pa

16 (a) Informant James Lean
(b) Address Baltimore Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/48 (month) (day) (year)
(c) Cemetery or crematory Rose Hill
Location Hagerstown Md

18 (a) Funeral director A K Hoffman
(b) Address Hagerstown Md

MAR 26 1948 (Date rec'd by registrar) (b) Huntington Williamsport, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26 1948, at 12:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-18 1947, to 3-26 1948, and that I last saw h[illegible] alive on 3-25 1948.

	Duration
Immediate cause of death: Carcinoma of Stomach	19 mos.
Due to:	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation 1-3-47

Major findings of operation: Carcinoma of Cardia Body Stomach

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leon Cashman M. D.

Address 1201 Poplar Grove St Date signed 3-26-48

VS 150

661599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 661599

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2746 Shirley Ave

(c) Hospital or institution: Home Not Carmel Sanatorium

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 - 13

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2746 Shirley Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret M Bohl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Edward E

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1886

8. AGE: Years 61 Months 9 Days 1 If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Ernst Noltzel

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Francis Unknown

MOTHER 15. Birthplace Germany

16 (a) Informant Elsie Wagner

(b) Address 3701 N Calvert St

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 3/29/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Location Baltimore Co MD

18 (a) Funeral director Pelham & Son

(b) Address 1219 E Pratt St

19 (a) MAR 26 1948 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1948 at 6 39 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 21 1941 to March 25 1948 and that I last saw him alive on March 27 1948

Immediate cause of death Coronary Thrombosis — Duration Sudden

Due to Arteriosclerotic Heart disease

Due to

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Louis J Blum M. D.

Address 2310 Eutaw Place Date signed 3/25/48

VS 152

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 61600

61600 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2221 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2221 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARENDA KILSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1867

8. AGE: Years	Months	Days	If less than one day
80	2	25	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name William Wilson
13. Birthplace Md.

MOTHER
14. Maiden Name Mary J. Handy
15. Birthplace Md.

16 (a) Informant Mrs Helen L. Hill
(b) Address 2221 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-26-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem.
Location Anne Arundel Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) MAR 26 1948 (Date rec'd by registrar) (b)

MEDICAL CERTIFICATION P

20. DATE OF DEATH March 23, 1948, at 9:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-23-1948 to 3-24-1948 and that I last saw h alive on 3-24-1948

Immediate cause of death: Acute Myocardial Insufficiency — Duration: 2 days
Due to: Hypertension & Cardiac
Due to: Senile Debility
Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Crawford Higgins M. D.
Address 2265 Madison Ave. Date signed 3-26-48

V S 150

G61601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G61601

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Rochambeau Apartments
(b) Street address — 1 W. Franklin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1 West Franklin St. (If rural give location)
(e) Citizen of foreign country? ----- (Yes or No) If yes, name country --------

3 (a) **FULL NAME** Josephine M. Armstrong

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ---------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ----------

8. AGE: Years: About 71 | Months: -- | Days: -- | If less than one day: --hr. ---min.

9. Birthplace Harford County, Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business ----------

MOTHER / FATHER

12. Name Thomas Armstrong

13. Birthplace Ireland

14. Maiden Name Elizabeth McVey

15. Birthplace Ireland

16 (a) Informant Mrs. Elizabeth K. Dunnigan
(b) Address 1 W. Franklin Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (c) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) (Date) MAR 26 1948 (Signature of Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1948, at 8:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14- 1948, to 3-24- 1948, and that I last saw her alive on 3-23- 1948.

Immediate cause of death: Crebral Hemorrhage & Right Hemiplegia. — Duration: 10 Days

Due to: Arteriosclerosis. — Duration: 8yrs.

Due to: —

Other Conditions: Chronic Myocardi tis. (Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert S. Dingwall M. D.
Address 1613 E. North Ave. Date signed 3-25-48

83a

BC- 48-06667 ✓

661602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 661602

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette and Calhoun Sts.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 8 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore 16 Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2208 Clifford Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Hyman J. Schwartz

3 (b) If veteran, name war: —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 25, 1948

8. AGE: Years	Months	Days	If less than one day
			8 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Frank J. Schwartz

FATHER 13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Mildred Oppell

MOTHER 15. Birthplace Baltimore, Md.

16 (a) Informant Frank J. Schwartz

(b) Address 2208 Clifford Ave. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-26-48 (month) (day) (year)

(c) Cemetery or crematory Rosedale
Location Philadelphia Rd. Hamilton Md.

18 (a) Funeral director Jack Lewis Inc.

(b) Address 2100 Eastern Place Washington Boulevard, Md.

19 (a) MAR 26 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1948, at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-21 1948, to 3-25 1948, and that I last saw him alive on 3-24 1948.

Immediate cause of death	Duration
Atelectasis	
Due to Prematurity.	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. Allan Caywell M.D.
Address 1 Franklin Sq. Date signed 3/25/48

VS 150

C61603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C61603

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 709 South Glover Street
(c) Hospital or institution: - - None - - -
(d) Length of stay in hospital or inst. (yrs., mos., or days) - - 11
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 709 South Glover Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country - - - -

3 (a) FULL NAME MARGARET WEBER

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Conrad M. Weber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 22, 1882

8. AGE: Years	Months	Days	If less than one day
65	7	2	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name Louis Ott
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Cecelia ?
15. Birthplace Baltimore, Maryland

16 (a) Informant Evelyn Eichenberg-Daughter
(b) Address 709 South Glover Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-27-1948 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Eastern Avenue Extension

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 1901 Eastern Avenue, Balto. 31

19 (a) MAR 26 1948 (Date rec'd by registrar) (b) Kentucky for Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1948, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/9 1948 to 3/24 1948 and that I last saw h[illegible] alive on 3/23 1948

Immediate cause of death Hypertensive Cardio-sclerotic disease — Duration 2 hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Mitchell F. Hutchinson M.D.
Address 1016 S. East Ave. Date signed 3/26/48

VS 130

661604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 661604

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3706 Nortoma Rd
(c) Hospital or institution: The Mount 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4105 Fairview Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max Saperstein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 76 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russia (State or county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Davedy
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Lena Saperstein
(b) Address 4105 Fairview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-26-48 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh
Location Dundalk Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 410 Eutaw Place

19 MAR 26 1948 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-25- 1948 at 6 A M 35

21. I certify that death occurred on the date above stated; that I attended deceased from 4/7/48 19 48, to 3/24/48 19 48, and that I last saw him alive on March 24 19 48

Immediate cause of death: Cerebral Hemorrhage — Duration
Due to: Arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. I. Lisansky M. D.
Address 3210 Eutaw Pl Ave Date signed

March 28/48

VS 139

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 661605

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3301 Chestnut Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3301 Chestnut Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lulas Grace Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 27-1877

8. AGE: Years	Months	Days	If less than one day
70	4	26	hr. min.

9. Birthplace Baltimore Co-Md.
(Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name Benjamin F. Baker
13. Birthplace Pa:

MOTHER
14. Maiden Name Liza Krout
15. Birthplace Pa:

16 (a) Informant Ada Rebecca Baker
(b) Address 3253 Chestnut Ave

17 (a) Burial (b) Date thereof 3-26-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

MAR 26 1948 Huntington Williams
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1948 at 6:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from many 19 4 years 19
and that I last saw h alive on 3/24 1948
Immediate cause of death Myocardial infarction, Acute

	Duration
Due to Coronary thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Roland Canole M. D.
Address 133 W St & Chestnut Ave Date signed 3/26/48
Balto Md X

661606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

661606 Registered No.

The entries on this certificate, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3615 Falls Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3530 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Asa Tydings

3/24/48

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-10-7290

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Virginia M. Tydings

6 (c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): April 11 1878

8. AGE: Years: 69 Months: 11 Days: 13 If less than one day: hr. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual Occupation: Machinist, Retired

11. Industry or business: Glenn L. Martin

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Virginia M. Tydings
(b) Address: 3530 Roland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: March 27 1948 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Woodlawn, Md.

18 (a) Funeral director: Paul C. Langenthal
(b) Address: 2415-17 Chestnut Ave.

19 (a) MAR 25 1948 (Rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1948 at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 16 1948 to March 24 1948, and that I last saw h[illegible] alive on March 20 1948

Immediate cause of death: Acute dilatation of the heart caused by obliteration of the coronary arteries

Due to: Coronary Sclerosis

Due to: Hypertensive Hypertrophy of Heart [illegible]

Due to:

Other Conditions: ✓
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: none

Duration
5 weeks
10 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: H. A. Lillich M.D.

Address: 4415 Forest Park Ave. Date signed: 3/27/48

VS 150

X

G61607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

G61607

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2569 W. Cullen St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2569 W. Cullen St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harriett Dawson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Levi T.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1883

8. AGE: Years 64 65 | Months 9 | Days 12 | If less than one day hr. min.

9. Birthplace Severna Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Richard Waters

FATHER 13. Birthplace Severn, Md.

MOTHER 14. Maiden Name Unknown

MOTHER 15. Birthplace

16 (a) Informant Mrs. Ina Maynard

(b) Address 5 W. Fairhaven Ave. Govans, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-26-1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel

Location Baltimore, Md.

18 (a) Funeral director Mr. George N. Hallam

(b) Address 1691 Druid Hill Ave.

19 (a) MAR 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-22 1948 at 11.4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1 1948 to 3-22 1948, and that I last saw h alive on 3-22 1948.

	Duration
Immediate cause of death Ventricular Heart Failure	1
Due to	
Due to	
Other Conditions (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Charles J. Wendell M. D.

Address 861 Hamburg Date signed 3-24-48

VS 150

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 061608

061608

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 627 S. Montford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 627 S. Montford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Catherine F Fijol

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Fijol
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Joseph Fijol
(b) Address 627 S. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/48 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Balto. City

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern ave

19 (a) MAR 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 March 1948 at 9.00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 22 Dec. 1947 to 25 Mar 1948, and that I last saw her alive on 4 Mar. 1948

Immediate cause of death: Cardiac failure — Duration: 1 hr.

Due to Cardiac hypertrophy and dilatation.

Due to Arteriosclerotic C-V disease.

Other Conditions Generalized arteriosclerosis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Drozd M. D.

Address 2601 Eastern Ave Date signed 3/26/48

X

C661609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a ✓

Registered No. C661609

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor & Duke land St
(c) Hospital or institution:
WEST BALTIMORE GENERAL HOSPITAL 13-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3409 Chestnut ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES FRANKLIN DONNELLY

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-10-3779

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 31-1890

8. AGE: Years 57 | Months 6 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Cotton Mill

FATHER
12. Name Frank Donnelly
13. Birthplace Md

MOTHER
14. Maiden Name Amanda E. Boldon
15. Birthplace Md

16 (a) Informant Mrs Marie Taylor
(b) Address 3533 Kenwick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/48 (month) (day) (year)
(c) Cemetery or crematory St. Marys Cem
Location Hampden, Balto Md

18 (a) Funeral director Geo. E. Boyer Jr
(b) Address 1512 Hollins St

19 (a) MAR 26 1948 (Date rec'd by registrar) Registrar for Baltimore City

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1948, at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-22 1948 to 3-24 1948, and that I last saw h. alive on 3-24 1948.

Immediate cause of death	Duration
SHOCK	
Due to ACUTE MYOCARDIAL INFARCTION	
Due to CORONARY ARTERIOSCLEROSIS	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gilbert Gutstadt M. D.
Address West Baltimore Gen. Hosp. Date signed 3/26/48

VS 150

X

C61610

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. C61610

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Colored
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) Just Come
(e) Length of stay in Baltimore (yrs., mos., or days) 34 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County St. Mary's Co.
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. none (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anthony Frank
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: M
6 (b) Name of husband or wife: Bertha Frank
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12/22/1885

8. AGE: Years 62 | Months 3 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Daughter
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/48 (month) (day) (year)
(c) Cemetery or crematory St Michaels
Location Ridge, Md

18 (a) Funeral director P. B. Robinson
(b) Address Leonardtown, Md

19 MAR 26 1948 (Date rec'd by registrar) (Funeral Director for Williamsville, Md.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1948, at ..... M

21. I certify that death occurred on the date above stated that I attended deceased from March 21 1948 to March 26 1948 and that I last saw him alive on March 26 1948.

Immediate cause of death Bronchopneumonia Ca — Duration .....
Due to ..... — Duration .....
Due to ..... — Duration .....
Other Conditions ..... — Duration .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which place) While at work?
(e) Means of injury .....

23. Signature L. M. Jernigan M. D.
Address Mercy Date signed 3/26/48

L. M. Jernigan

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

61611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 61611

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3005 Herbert Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3005 Herbert Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Baer (Mamie Baer.)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 1. 1886.

8. AGE: Years	Months	Days	If less than one day
61	11	23	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Michael Baer,
13. Birthplace Germany.

MOTHER
14. Maiden Name Dora Isaacs.
15. Birthplace Germany.

16 (a) Informant Mrs. Daisy Levy (Sister)
(b) Address 3827 W. Cold Spring Lane.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3.26.48. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Harris Lowenheim & Sons
(b) Address 1902 Eutaw Place.

19 (a) MAR 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-24-1948, at 11:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions Diabetes

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Waldeis M.D.
Medical Examiner.
Date signed 3-25-48

937

661612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 661612

661612

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 307 McMechen St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Monroe Riggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1909

8. AGE: Years 38 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace Trenkham, Va.
(Town, county, and state)

10. Usual Occupation Motorman

11. Industry or business Balto. Transit Co.

FATHER
12. Name Chas. M. Riggs
13. Birthplace Va.

MOTHER
14. Maiden Name Grace
15. Birthplace Va.

16 (a) Informant Mrs. Hill, Md.
(b) Address Charlottesville, Va.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/26/48 (month) (day) (year)
(c) Cemetery or crematory Charlottesville,
Location Charlottesville, Va.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.

19 (a) MAR 26 1948 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-25-1948, at 6 40 P.M.

21. I attended the deceased from Last Charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull & Intracranial Hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/25/48 at 6 45 P. M. 13/3
(b) Where did injury occur? 2225 N. Fulton Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public (Tavern) While at work? No
(d) Means of injury Slipped & fell down stairs (inside)

23. Signature Carl M. Riggs M.D.
Medical Examiner
Date signed 3/26/48

VS 151

661613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 661613

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 819 N. Fremont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 ds
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 819 N. Fremont Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME James H. Watkins

3 (b) If veteran, name war: 1st World War
3 (c) Social Security Account No. 197-01-3715

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1901

8. AGE: Years	Months	Days	If less than one day
47	1	3	— hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Chef Cook
11. Industry or business Hotel

FATHER
12. Name Lemuel Watkins
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Rosie Treherne
15. Birthplace Baltimore, Md.

16 (a) Informant Marion Watkins
(b) Address 819 N. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-26-1948 (month) (day) (year)
(c) Cemetery or crematory Int. Calvary
Location

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 322 N. Schroeder St.

19 (a) MAR 26 1948 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3.22.48 19 , at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9.3.46 19 , to 3.22.48 19 , and that I last saw him alive on 3.22.48 19 .

Immediate cause of death: uremia — Duration 30 hrs
Due to: Hypertensive cardio renal vascular Disease — 9.3.46
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James M. Parr M. D.
Address 400 N. Carrollton Ave Date signed 3.22.48

VS 3

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

061614

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a

Registered No. 061614

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 McHENRY ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 McHenry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sophia McINTIRE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband ~~or wife~~ JAMES - H.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 8 - 1886

8. AGE: Years 61 62 | Months 7 | Days 16 | If less than one day hr. min.

9. Birthplace BALTIMORE - MD.
(Town, county, and state)

10. Usual Occupation STORE KEEPER.

11. Industry or business CONFECTIONERY

FATHER
12. Name
13. Birthplace UNKNOWN.

MOTHER
14. Maiden Name
15. Birthplace UNKNOWN

16 (a) Informant BENJAMIN J. STRIPPY
(b) Address 1227 CIRCLE DRIVE

17 (a) BURIAL (b) Date thereof 3-27-8
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location OLD FREDERICK

18 (a) Funeral director Charles W. Faehnrich
(b) Address 703 McHenry St.

19 (a) MAR 26 1948 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-24-48 19 , at 1-10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 1945 to 3/24 1948 and that I last saw h er alive on 3-24 1948.

Immediate cause of death	Duration
Acute Cardiac Failure	1 da
Due to Cardio Vascular Renal	
Due to Disease	3 yr
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph G. Lawlor M.D.
Address 6 W. Washington St. Date signed 3-26-48

VS 150

WALERIA SAJNUK

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127a

Registered No. G61615

G61615

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 120 S. Washington Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 8 Jears

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 120 S. Washington Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country Poland

3 (a) FULL NAME Waleria Sajnuk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Aleksander Sajnuk 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Jakub Filipkowski
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Sokolowski
15. Birthplace Poland

16 (a) Informant Joseph Sajnuk (Son)
(b) Address 120 S. Washington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-48 (month) (day) (year)
(c) Cemetery or crematory Scranton Penna.
Location

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 MAR 26 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION 1158

20. DATE OF DEATH March 25 1948, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1947 to 25 March 1948 and that I last saw her alive on 3-25 1948

Immediate cause of death Congestive Heart Failure — Duration 2 days

Due to Hypertension C.-V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Dec 11, 47.

Major findings of operation: Chronic Cholecystitis

of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Vogel Jr. M. D.
Address 2401 E. Monument St. Date signed 3-26-48

VS 150

X

061616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 061616

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1612 Cliftview Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 Cliftview Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adella W. Barth

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Chas. H. Barth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March. 2, 1873

8. AGE: Years 75 | Months 0 | Days 23 | If less than one day: hr. min.

9. Birthplace: Bermuda Islands (Town, county, and state)
10. Usual Occupation: none
11. Industry or business

FATHER
12. Name: Nathaniel Butterfield
13. Birthplace: Unknown "

MOTHER
14. Maiden Name: "
15. Birthplace: "

16 (a) Informant: Mr. Julius Barth
(b) Address: 1612 Cliftview Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar. 29/48 (month) (day) (year)
(c) Cemetery or crematory: Moreland Mem. Park
Location: Balto. Md.

18 (a) Funeral director: Philip Sterling Sons
(b) Address: 2024 Orleans St.

19 MAR 26 1948 (Date rec'd by registrar) (b) Interior for Williamsport Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25/48 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1/47 19 to 3/25/48 19 , and that I last saw her alive on 3/25 19 48.

Immediate cause of death: Acute Coronary Thrombosis — Duration: years
Due to: Coronary Sclerosis — Duration: years
Due to: — Duration:
Other Conditions: Hypertension — Duration: years
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: C. J. Mendelis M. D.
Address: 651 N Broadway Date signed: 3/26/48

V S 150

X

G61617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 B

Registered No. G61617

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2834 Clifton Ave. #16 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carroll WORTHINGTON KETTLE

3 (b) If veteran, name war NONE

3 (c) Social Security Account No. NONE

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife NORA R. KETTLE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT 29, 1886

8. AGE: Years 61 | Months 5 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired (FISH BUSINESS)

11. Industry or business

FATHER
12. Name ALFRED J. KETTLE
13. Birthplace ENGLAND

MOTHER
14. Maiden Name SARAH E. HOBBS
15. Birthplace MD.

16 (a) Informant MR. ROBERT J. KETTLE
(b) Address 2834 CLIFTON AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/29/48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PK
Location BALTO., MD.

18 (a) Funeral director WM. J. REGNER & SONS
(b) Address BALTO. MD.

19 (a) MAR 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1948, at 4:25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 26 1948 to March 25 1948, and that I last saw him alive on March 25 1948.

	Duration
Immediate cause of death: Cardio-respiratory failure	30 min.
Due to: Paralytic Ileus	6 days
Due to: Portal Cirrhosis	? years
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Paralytic Ileus & Portal Cirrhosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred N. Dann M. D.
Address Md. General Hosp. Date signed 3/25/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G61618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G61618

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 Roslyn Ave.
(c) Hospital or institution: Kenesaw Rest Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2702 W. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country —

3 (a) FULL NAME ANNA MYER

3 (b) If veteran, name war No | 3 (c) Social Security Account No. No

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. WIDOW

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. Age: Years about 86 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace UNKNOWN (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name UNKNOWN
13. Birthplace "

MOTHER 14. Maiden Name "
15. Birthplace "

16 (a) Informant DR. F. P. C. HELM
(b) Address 2757 W. North Ave

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 3/27/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Location CINCINNATI, OHIO

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTO., MD.

19 MAR 26 1948 (Date rec'd by registrar) Hunting for Williamsville, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25 1948, at 1:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 3 19 48 to March 25 19 48, and that I last saw her alive on March 24 19 48

Immediate cause of death — Duration

Coronary Occlusion

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. P. C. Helm M. D.

Address 2757 W. North signed 3/26/48

VS 150

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied

C61619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9 2a

Registered No. C61619

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1824 N. MONTFORD Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ABOVE ADDRESS 10 YRS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1824 N. MONTFORD Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS H. MATZEN

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: DIVORCED
6 (b) Name of husband or wife: MARGARET CATHERINE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT , 1879

8. AGE: Years 68 | Months 5 | Days | If less than one day ____ hr. ____ min.

9. Birthplace BALTIMORE , MD
(Town, county, and state)

10. Usual Occupation ELEVATOR INSPECTOR
11. Industry or business BALTO. CITY

FATHER
12. Name JOHN MATZEN
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15 Birthplace "

16 (a) Informant MR. HARRY H. SCHUMACHER
(b) Address 2610 FRANCIS ST.

17 (a) BURIAL (b) Date thereof 3/27/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory SCHWARTZ
Location O'DONNELL ST. BALTO., MD

18 (a) Funeral director WM J. TICKNER & SONS
(b) Address BALTO. MD

19 MAR 26 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24 1948, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from December 1947 to March 1948 and that I last saw h. alive on March 24 1948.

Immediate cause of death (a) Cardiac Dilatation — Duration 1 Day
Due to (b) Aortic Insufficiency — 2 years
Due to (c) Bronchiectasis
Due to (d)
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert A. Dyer M.D.
Address 906 E. North Ave Date signed 3-25-48

VS 150

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

661620 — Registered No. 661620

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2717 MOSHER ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2717 MOSHER ST (If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN ALEXANDER ZIMMERMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. 406-06-8472

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife IDA E. ZIMMERMAN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) AUG. 20, 1868

8. AGE: Years	Months	Days	If less than one day
79 86	7	3	hr. min.

9. Birthplace ? (Town, county, and state)
10. Usual Occupation CLERK (RETIRED)
11. Industry or business B & O R.R.

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant MRS. IDA E ZIMMERMAN
(b) Address 2717 MOSHER St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/27/48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PK
Location BALTO., MD.

18 (a) Funeral director WM. J. RECKNER & SONS
(b) Address BALTO., MD.

19 (a) MAR 26 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23/48 19 , at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 23 Mar 1948 to 23 Mar 1948, and that I last saw him alive on 23 Mar 1948

Immediate cause of death	Duration
Carcinoma of larynx	2 yrs.
Due to	
Due to	
Other Conditions Probable terminal mediastinitis and cerebral metastases. (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Emil H. Henning Jr M. D.
Address 4580 Edmondson Ave Date signed 24 Mar 48

VS 150

Please write clearly and legibly. Physicians: please write the causes of death clearly and legibly. Information should be correctly supplied. The correct age is especially important.

661621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8.3a

Registered No. 661621

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 349 MARYDELL RD.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 349 MARYDELL RD.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara D. Ashmore

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife HARRY B. ASHMORE
6 (c) If alive, give age 1884 years

7. Birth date of deceased (mo., day, yr.) APR. 5, (1883)

8. AGE: Years	Months	Days	If less than one day
64(63)	11	19	hr. min.

9. Birthplace REISTERSTOWN, MD
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name COLUMBUS BARRY
13. Birthplace N. Y.

MOTHER
14. Maiden Name CLARA MORGAN
15. Birthplace REISTERSTOWN MD.

16 (a) Informant MRS. HARRY B. ASHMORE
(b) Address 349 MARYDELL RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/27/48 (month) (day) (year)
(c) Cemetery or crematory WOODLAWN
Location BALTO CO. MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTIMORE MD.

19 MAR 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 March 1948, at 5 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Vascular Accident

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammon Jr. M.D.
Medical Examiner.
Date signed 24 Mar. 48

VS 191

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

661622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 661622

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4100 Curtis Ave - 26
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore 18 (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 26 Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 4100 Curtis Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Emerson M. Jenkins

3 (b) If veteran, name war W. W. #1

3 (c) Social Security Account No. 213-06-5144

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of ~~husband~~ or wife Dorothy Lee Jenkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29-1897

8. AGE: Years	Months	Days	If less than one day
50 51	11	25	hr. min.

9. Birthplace Mississippi (Town, county, and state)
10. Usual Occupation Dry Dock Operator
11. Industry or business Md Dry Dock Co

FATHER
12. Name Robert C. Jenkins
13. Birthplace Mississippi

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs Dorothy Lee Jenkins
(b) Address 4100 Curtis Ave - 26

17 (a) 3/27/48 Burial (Burial, cremation, or removal) (b) Date thereof 3/27/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Brooklyn
Location Gov. Ritchie Highway

18 (a) Funeral director Milton Schilling
(b) Address 3914 Hanover St - 25

19 MAR 26 1948 (Date rec'd by registrar) (b) Huntington Williams MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1948, at 10.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/21/48 to 3/23 1948 and that I last saw h alive on 3/22 1948

Immediate cause of death

Duration

Heart failure

Due to chronic myocarditis

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 203 Polepenn Date signed

VS 150

661623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 661623

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1931 W MULBERRY ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1931 W. MULBERRY ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME STEWART M JOHNSON

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of ~~husband or~~ wife MARTHA R (DUCKETT)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 10, 1885

8. AGE: Years	Months	Days	If less than one day
62	3	14	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation INSURANCE AGENT
11. Industry or business MONUMENTAL LIFE

FATHER
12. Name CHARLES A JOHNSON
13. Birthplace MD

MOTHER
14. Maiden Name MARTHA A
15. Birthplace MD

16 (a) Informant MRS MARTHA R JOHNSON
(b) Address 1931 W. MULBERRY ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MARCH 27, 1948 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location 3801 FREDERICK AVE

18 (a) Funeral director Henry H Wetzel
(b) Address 4101 EDMONDSON AVE

19 (a) MAR 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 24 1948, at 12 25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from JULY 1947 to 3/24 1948 and that I last saw him alive on 3/23 1948

Immediate cause of death CORONARY OCCLUSION — Duration 3/24/48
Due to ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — 7/47
Due to
Other Conditions ACUTE PHARYNGITIS — 3/22/48
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury?
23. Signature Howard E Crouse M. D.
Address 3609 Edmondson Ave Date signed 3/26/48

VS 150

G61624

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. G61624

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp. 13-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15d.
(e) Length of stay in Baltimore (yrs., mos., or days) 73yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Home for Incurables (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry William Frauenth.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 16 Sept 47. 1874

8. AGE: Years 73 | Months 6 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER / FATHER
12. Name Joseph Wm. Frauenth
13. Birthplace New Jersey
14. Maiden Name Sallie K Doughty
15. Birthplace New Jersey.

16 (a) Informant Miss Amelia Frauenth.
(b) Address 412 Normandy Ave Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof MARCH 27 1948 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location 3801 FREDERICK RD

18 (a) Funeral director Harry H Wittyle
(b) Address 4101 Edmondson Ave

19 (a) MAR 26 1948 (Date rec'd by registrar) (b) Huntington Hollins Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 Mar 1948, at 7:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10 Mar 1948 to 25 Mar 1948, and that I last saw h alive on 25 Mar 1948.

Immediate cause of death	Duration
Coronary artery occlusion	
Due to	
Due to	
Other Conditions Generalized arteriosclerosis. Cardiac at [illegible] (Include pregnancy within 3 months of death)	

Date of operation 17 Mar 48.
Major findings of operation: Lumbar sympathectomy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. W. Sohmer
Address Union Memorial Hosp. Date signed 25th Mar 48

VS 150

G61625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G61625

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square 95

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1735 Clifton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph McDADE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Eva M. Hill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 14, 1905

8. AGE: Years 42 | Months 5 | Days 11 | If less than one day hr. min.

9. Birthplace Scotland (Town, county, and state)

10. Usual Occupation Rigger

11. Industry or business McDade Transfer

FATHER
12. Name Bernard McDade
13. Birthplace Scotland

MOTHER
14. Maiden Name Jeanne McCabe
15. Birthplace Scotland

16 (a) Informant William McDade
(b) Address 1542 Northwick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/48

(c) Cemetery or crematory New Cathedral
Location 3901 old Frederick Rd

18 (a) Funeral director Harry H. Watkins
(b) Address 4101 Edmondson Ave

19 MAR 26 1948 (Date rec'd by Registrar) Huntington Williamsville

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25/48 19 at 6:50 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive Cardiovascular Disease
due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 4/25/48

VS 151

X

PRINT PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G61626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G61626

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4515 Garrison Blvd.
(c) Hospital or institution: Haven Nursing Home
(d) Length of stay in hospital or inst, (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3610 Clifton Ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Vertie Snyder

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NO

4. Sex: FM
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 72 | Months | Days | If less than one day: hr. min.

9. Birthplace Minnesota (Town, county, and state)

10. Usual Occupation None

11. Industry or business "

MOTHER / FATHER

12. Name Harry Snyder

13. Birthplace Unknown

14. Maiden Name Virginia Snyder

15. Birthplace Unknown

16 (a) Informant Mrs. William R. Mason
(b) Address 2135 Mt. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) Received by (Signature) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1948, at 9:2[illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from March 13 1948 to Mar 26 1948 and that I last saw h[illegible] alive on March 26-48.

Immediate cause of death: Hemiplegia — Left Brain Hemorrhage — Duration: 13 days
Due to: Hemorrhage — Left Internal capsule
Due to: —
Other Conditions: —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. H. Phillips M. D.
Address 3307 Edmondson Ave Date signed 3-26-48

VS 150

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. 61627

061627

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 159 W Cross Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs.) mos., or days) 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 159 W. Cross Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Doughty

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Willie Doughty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/15/1920

8. AGE: Years 27 | Months 7 | Days 10 | If less than one day hr. min. 28

9. Birthplace Manning S.C
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name E. W. McFadden
13. Birthplace S.C.

MOTHER
14. Maiden Name Eliza Rose
15. Birthplace S.C.

16 (a) Informant Willie Doughty
(b) Address S C

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-27-48 (month) (day) (year)
(c) Cemetery or crematory Lynter
Location S. C.

18 (a) Funeral director Isaiah L. Brown
(b) Address 108 W Montgomery St

19 (a) MAR 27 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25/48 19 , at 6 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/19/ 1948 to 3/25/ 1948
and that I last saw her alive on 3/24 1948

Immediate cause of death

Duration

Carcinoma of lungs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. D. Taylor

Address 152 Harlem Ave Date signed 3/26/48

VS 150

C61628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 207

Registered No. C61628

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town 1410 Carroll St
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Md (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Ben Brown
13. Birthplace Md

MOTHER
14. Maiden Name Alethia Culley
15. Birthplace Md

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-29-48 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location Balto County

18 (a) Funeral director Isaiah L Brown Son
(b) Address 108 W Montgomery St

19 (a) MAR 27 1948 (b) Huntington Wallace Registrar
(Must be filed within 5 days by law)

VS 193

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1948 at 10 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/25 1948 to 19; and that I last saw him alive on 3/25 1948.

Immediate cause of death	Duration
Acute Cardiac failure	12 hr.
Due to Syphilitic Cardiovascular disease with aortic insufficiency and regurgitation	
Due to Syphilitic Aneurysm of thoracic aorta.	3+ yrs.
Other Conditions arteriosclerosis General paresis, moderate.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving Frew

Address Johns Hopkins Hospital Date signed 3/25/48 M.D.

C61629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 F

Registered No. C61629

The correct age is especially important. Physicians: please write the cause of death clearly and legibly. Information should be carefully supplied. The

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3706 Liberty Heights

(c) Hospital or institution: (at home)

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore City

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3706 Liberty Heights (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country —

3 (a) FULL NAME Nellie Silver Hayden

3 (b) If veteran, name war No

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife W. Reid Hayden

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug-31-1886

8. AGE: Years 61 | Months 6 | Days 26 | If less than one day hr. min. 24

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER

12. Name Dr. Howard C. Silver

13. Birthplace West Virginia

MOTHER

14. Maiden Name Mollie McComas

15 Birthplace unknown

16 (a) Informant Howard R Hayden - Son

(b) Address 3706 Liberty Heights

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 27-48 (month) (day) (year)

(c) Cemetery or crematory Green Mount

Location Baltimore

18 (a) Funeral director Stewart Warner Co.

(b) Address 108 Worth Ave

19 (a) MAR 27 1948 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 24 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1948 to Mar 24 1948 and that I last saw her alive on Mar 24 1948

Immediate cause of death Carcinoma - Liver & Peritoneal Cavity

Due to Carcinoma of Gall-bladder

Due to (over)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Jan 3, 1948

Major findings of operation Ca. of Gall-bladder: metastases to Liver

of autopsy: None

Duration
Mar 19, 47

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Carroll Sollard M. D.

Address 25 N Charles St Date Mar 25 48

VS 150

C61630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. C61630

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3005 Herbert St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3005 Herbert Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stephen Shyers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Frances R. Shyers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 15 1871

8. AGE: Years 76 | Months 4 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace New Brunswick N.J.
(Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Glen L. Martin Co.

FATHER
12. Name Stephen L. Shyers
13. Birthplace New York N.Y.

MOTHER
14. Maiden Name Lavinia P. Filter
15. Birthplace N.J.

16 (a) Informant Josephine Filter Shyers
(b) Address 4305 Wickford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) MAR 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-24- 1948, at 11 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Malone, M.D.
Medical Examiner.
Date signed 3-25-48

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G61631

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G61631

The Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1513 N. Wolfe Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 N. Wolfe Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ernest Pegelow

3 (b) If veteran, name war: World War # 1

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Viola Brogley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 23, 1878

8. AGE: Years 69 | Months 7 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name George Pegelow
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Hazzel
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Bertha Spillman
(b) Address 1513 N. Wolfe Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 3/29/48 (month) (day) (year)
(c) Cemetery or crematory National Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) MAR 27 1948 (Date rec'd by registrar) (b) Huntington McClenahan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 16 1947 to 3-24 1948
and that I last saw h... alive on ... 19...

Immediate cause of death: Cerebral Arteriosclerosis — Duration: 3 yr

Due to:

Due to:

Other Conditions: Myocardial Degeneration — 2 days
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel Mallet
Address 1500 N Broadway Date signed 3/29/48

VS 150

X

G61632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 110B

Registered No. G61632

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 666 W Fayette St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George L. Kennedy.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
M	W	Widowed

6 (b) Name of ~~husband or~~ wife Rose M. Kennedy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 5th 1873

8. AGE: Years	Months	Days	If less than one day
75	1	20	hr. min.

9. Birthplace La.
(Town, county, and state)

10. Usual Occupation Roaming house owner

11. Industry or business Retired Actor

MOTHER / FATHER

12. Name (Mother) Kennedy

13. Birthplace "

14. Maiden Name "

15. Birthplace "

16 (a) Informant Lorraine Clay (Sister in law)

(b) Address Elks Club - Fayette nr Howard

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/29/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Western

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

19 (a) MAR 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25 1948 at 9:7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24 1948 to 3/25 1948 and that I last saw h[illegible] alive on 3/25 1948

Immediate cause of death Resp. Cond Collapse

Probable thyroid storm

Adenomatous Colloid goiter

Due to Generalized fibrillation

Cardiac Decompensation

Due to Hydrotherapy nurse

Debydration

Other Conditions Malnutrition

(Include pregnancy within 3 months of death)

Duration

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H W Kennedy Jr

Address Redwood & Greene Date signed 3/25/48 M.D.

VS 133

G61633

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G61633

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3300 Noble st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3300 Noble st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary E. Anzengruber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband ~~or wife~~: John Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10th 1869

8. AGE: Years 78 | Months 7 | Days 16 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name William Mumma
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary C. Dunlap
15. Birthplace Pa.

16 (a) Informant John R. Anzengruber
(b) Address 3300 Noble St

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/29/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ York M. E. Church
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 217 St. Paul St.

19 (a) MAR 27 1948 (b)
(Date rec'd by registrar) Burlington for Williams, Reg.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 26th 1948, 10 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 24 1948, to Mar. 26 1948, and that I last saw her alive on Mar. 24 1948

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Hypertension	
Due to	
Other Conditions Cardiovascular Disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles O. MacMunn M. D.
Address 911 E. Balto. St. Date signed Mar. 26, 1948

VS 150

83a

G61 Abbott - 1509-Silvertop Hgts

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G61634

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4408 Springdale Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4408 Springdale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Spencer Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widow

6 (b) Name of husband or wife W. C. Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12, 1867

8. AGE: Years	Months	Days	If less than one day
80	6	13	hr. - min.

9. Birthplace Reisterstown, Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Wm B. Windsor
13. Birthplace Unknown

MOTHER
14. Maiden Name Harriet Dutrow
15. Birthplace Harpers Ferry, W. Va.

16 (a) Informant Nellie David Hancock
(b) Address 4408 Springdale Ave

17 (a) Burial (b) Date thereof 3-27-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Ellsworth Armsworth
(b) Address 3911 Liberty Heights Ave

19 MAR 27 1948 Huntington Williams
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-25 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to March 1948 and that I last saw her alive on 3-25 1948

Immediate cause of death	Duration
Pneumonia Type	
Due to Hemorrhage Arteriosclerosis	
Due to Chronic Nephritis	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos H Abbott M.D.
Address 1509 Liberty Heights Date signed 3-26

C61635

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. C61635

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1908 Penna Ave
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 Penna Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Marion E. Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Bernard Taylor

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr) Aug 26 1895

8. AGE: Years 52 | Months 6 | Days 29 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business Own home

FATHER
12. Name Cornelius H. Jones
13. Birthplace Md

MOTHER
14. Maiden Name unknown
15. Birthplace Md.

16 (a) Informant Bernard Taylor
(b) Address 1908 Penna ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-48 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location md

18 (a) Funeral director George S. Kelson
(b) Address 1303 Pennsylvania ST

19 (a) MAR 27 1948 (b) Huntington Williams MD
Filed by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-24-1948, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-28-1948 to 3-24-1948, and that I last saw her alive on 3-23-1948.

Immediate cause of death: Myocarditis

Due to: Arteriosclerosis

Due to:

Other Conditions: Cerebral hemorrhage

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: unknown

Mar 24 1948

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank A. Saunders M. D.

Address 102 N. Stricker Date signed 3-26-48

VS 153

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

661636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1634

Registered No. 661636

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 702 W. Belvedere ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) X
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 702 W. Belvedere ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Barclay Voshell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife Dr. Allen F. Voshell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/6/1896

8. AGE: Years	Months	Days	If less than one day
52	2	18	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Delancey H. Barclay
13. Birthplace Conn.

MOTHER
14. Maiden Name Sophie C. Saulsbury
15. Birthplace Balto.

16 (a) Informant Dr. Allen F. Voshell
(b) Address 702 W. Belvedere Ave

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Mch 27/48 (month) (day) (year)
(c) Cemetery or crematory L. Park
Location 3809 Frederick Ave

18 (a) Funeral director John O. Mitchell & Son
(b) Address 1700 Eutaw Place

19 MAR 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 March 1948, at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Carbon Monoxide Poisoning

Due to Illuminating Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/25/48 ? at P. M.
(b) Where did injury occur? 702 W. Belvedere Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Gas heater or hot plate

23. Signature Wm. H. Kammer M.D.
Medical Examiner.
Date signed 24 Mar. 1948

VS 191

X

Please write plainly, with INDELIBLE INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

661637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

661637 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Fenby
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 4702 Fenby Ave (If outside city or town limits, write RURAL and give town)
(d) Street No. Balto Md (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Allen Thurman Amoss

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-6371

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Estelle S. Amoss
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 7 1886 1887

8. AGE: Years	Months	Days	If less than one day
61 (62)	2	19	hr. min.

9. Birthplace Howard Co Md (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Edgar L Amoss
13. Birthplace Md

MOTHER
14. Maiden Name Ida Barnes
15. Birthplace Md

16 (a) Informant Mrs Estelle Amoss
(b) Address 4702 Fenby Ave Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-29-1948 (month) (day) (year)
(c) Cemetery or crematory Mt View
Location Elkton Md

18 (a) Funeral director K. Higinbotham
(b) Address Elkton City Md

19 (a) MAR 27 1948 (Must be filed by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1948, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1948 to March 26 1948, and that I last saw h[illegible] alive on March 25 1948.

Immediate cause of death	Duration
Pulmon T b.	1 year.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. S. Hardesty M. D.
Address 350 S Bolair Pl Date signed 3/26/48

BC-KP-06671

G61638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G61638

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1729 E. Lombard
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy HAYES. (John Frederick) Hayes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~1 day~~ 3-26-48

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation new born

11. Industry or business

FATHER 12. Name John William Hayes

13. Birthplace Sumner, Georgia

MOTHER 14. Maiden Name Catherine Pruett

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Catherine Hayes

(b) Address 1729 E Lombard St Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/48 (month) (day) (year)

(c) Cemetery or crematory Evergreen

Location 6115 O'Donnell St

18 (a) Funeral director Doepel Bros.

(b) Address 1800 E Lombard St

19 (a) MAR 27 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26 1948 at M

21. I certify that death occurred on the date above stated, that I attended deceased from 3-25 1948 to 3-26 1948, and that I last saw h[illegible] alive on 3-26 1948.

Immediate cause of death	Duration
Resp failure	
Due to Congenital anomalies	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Bilat congen cataract

of autopsy: Congen Heart Dis

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Maxwell

Address Franklin Sq Hosp (Date signed) 3/27/48

VS 150

X

G61639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G61639

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: I E.Chase Street

(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County City

(c) City or town Baltimore (3)
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3612 Elkader Road
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME L.Eugene Gardiner

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-10-9191

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary E.Smith

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Feb.28th., 1904

8. AGE: Years	Months	Days	If less than one day
44	0	28	########## min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Resident Manager

11. Industry or business Hotel

FATHER
12. Name John C.Gardiner
13. Birthplace Indiana

MOTHER
14. Maiden Name Marie Antoinette Owens
15 Birthplace Maryland

16 (a) Informant Mrs.Mary E.Gardiner (Wife)
(b) Address 3612 Elkader Road

17 (a) Burial (b) Date thereof 3/29/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St.Johns,Long Green
Location Baltimore County,Maryland

18 (a) Funeral director George J.Ruth,Inc.
(b) Address 1735 Harford Avenue

19 (a) MAR 27 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26th., 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to Mch. 26 1948.
and that I last saw h. m alive on Mch 26 1948.

Immediate cause of death	Duration
Angina Pectoris	one hour
Due to Spasm of Coronary blood vessels followed by Spasm of cerebral vessels	
Due to	
Other Conditions This fatal attack was 3rd in one week	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature C.A.Rayburn M. D.

Address 1N Eager St Date signed 3/29/48

V S 150

G61640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G61640

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 124 Burnett Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 124 Burnett Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary R Leybold

3 (b) If veteran, name war No

3 (c) Social Security Account No. No

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Henry F Leybold

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19, 1880

8. AGE: Years 68 | Months | Days 7 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Henry Seibert
13. Birthplace Md

MOTHER
14. Maiden Name Dont know
15. Birthplace " "

16 (a) Informant Mrs Marie Metzger
(b) Address 124 Burnett Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 27, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto City

18 (a) Funeral director A. Howard Evans
(b) Address 1400 N Charles St

19 MAR 27 1948 (Date received by registrar) (b) Huntington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1948, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11 1948 to 3/26 1948, and that I last saw her alive on 3/24 1948.

Immediate cause of death Chronic myocarditis and myocardial degeneration - non rheumatic. — Duration 2 yrs

Due to

Due to

Other Conditions Cirsoic varicose ulcer left leg.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Seibert M. D.

Address 1216 Hanover St. Date signed 3/27/48

VS 150

G61641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

Registered No. G61641

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution: St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4107 Southern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Slater

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	

6 (b) Name of husband or wife Louise M. Slater
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1870

8. AGE: Years	Months	Days	If less than one day
77	10	12	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Holy Redeemer Cemetery

FATHER
12. Name John H. Slater
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Schmidt
15. Birthplace Germany

16 (a) Informant Mrs. John H. Slater
(b) Address 4107 Southern Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Mar. 29, 1948 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto., Md.

18 (a) Funeral director Lanahan Funeral Home
(b) Address 7401 Belair Road

19 (MAR 27 1948) (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26, 1948 at 4:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 14, 1948 to Mar. 26, 1948 and that I last saw him alive on Mar. 26, 1948

Immediate cause of death	Duration
Cardiac Resp. Failure	
Due to Cachexia	
Due to Hyperthermia	
Due to Carcinomatosis liver	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Carcinomatosis liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilton A. Bailey M.D.
Address St. Joseph's Hosp. Date signed 3/26/48

VS 150

G61642 SC = 48-06457 ✓ G61642

10 Basic

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ Hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 24,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3324 Fleet St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sohn

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-26-48

8. AGE: Years	Months	Days	If less than one day
			1 hr. 30 min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Peter Sohn
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Sue Bessie Kellner
15. Birthplace Baltimore Maryland

16 (a) Informant Charles Sohn
(b) Address 3324 Fleet St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/1948 (month) (day) (year)
(c) Cemetery or crematory Lakewood
Location Gr. Plot O'Donnell

18 (a) Funeral director Gerald Kopp
(b) Address 312-5 Hartland Ave

19 MAR 27 1948 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26-1948, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 26 19 48 to March 26 19 48, and that I last saw h-- alive on March 26 19 48

Immediate cause of death	Duration
Respiratory failure	
Due to prematurity - apnea	
Due to 8 D wks	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William F. Lowe M. D.
Address Bon Secours Hosp Date signed 3-26-48

X

661643 661643

BALTIMORE CITY HEALTH DEPARTMENT Registered No.

CERTIFICATE OF DEATH 194a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1933 Ramsay St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1933 Ramsay St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Alexius Winkler

3 (b) If veteran, name war None

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Louise N. Winkler

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) July 17, 1900

8. AGE: Years 47 Months 8 Days 9 If less than one day hr. min.

9. Birthplace Charles County, Md. (Town, county, and state)

10. Usual Occupation Maintenance

11. Industry or business Dupont Co.

FATHER 12. Name Tony Winkler

13. Birthplace Germany

MOTHER 14. Maiden Name Emily Adams

15. Birthplace Maryland

16 (a) Informant Louise Mannie Winkler

(b) Address 1933 Ramsay Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-29-48 (month) (day) (year)

(c) Cemetery or crematory St. Joseph's

Location Charles County, Md.

18 (a) Funeral director George L. Schwab

(b) Address 210 N. Frederick Ave.

19 (a) 3-28 1948 (Date rec'd by registrar) Huntington Hill, Baltimore, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26, 1948, at 10:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-26 1946 to 3-26 1946 and that I last saw him alive on 3-26-46 1946

	Duration
Immediate cause of death: Acute coronary occlusion	1 Hour
Due to: coronary sclerosis	unknown
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan Rosman

Address 206 S. Gilmor St Date signed 3-26-48 M. D.

VS 150

G61644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G61644 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Hopkins Apts., 31st & St. Paul
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days): life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: none
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 31st & St. Paul St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME: Sara Fusselbaugh Henderson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife: B. Harris Henderson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): November 1, 1894

8. AGE: Years	Months	Days	If less than one day
53	4	26	hr. min.

9. Birthplace: Baltimore County, Md. (Town, county, and state)
10. Usual Occupation: housewife
11. Industry or business

FATHER
12. Name: Robert Fusselbaugh
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Emma Presstman
15. Birthplace: Baltimore, Md.

16 (a) Informant: B. Harris Henderson
(b) Address: Hopkins Apts.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 3/29/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: 3801 Frederick Ave., Baltimore

18 (a) Funeral director: John O. Mitchell & Son, Inc.
(b) Address: 1900 Eutaw Place

19 (a) MAR 29 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27 1948, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1927 to March 27 1948.
and that I last saw her alive on 27 March 1948.

Immediate cause of death: Carcinoma (R breast) with metastases.. — Duration: over 5 yrs.
Due to: —
Due to: —
Other Conditions: —
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation: Extensive carcinoma of breast.
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: no
(b) Date of occurrence: — at M
(c) Where did injury occur? none — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? none (Specify type of place) While at work? —
(e) Means of injury: none

23. Signature: D. Orbus Powell M. D.
Address: 712 Park Ave. Date signed

VS 150

X

G61645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G61645

Registered No.

GM. 91349 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1743 E. Eager St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Bowie

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1866

8. AGE: Years 81 Months 8 Days 15 3 If less than one day hr. min.

9. Birthplace MD. Baltimore
(Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name 1 George Bowie
13. Birthplace 2 Baltimore, Md

MOTHER
14. Maiden Name 1 Sarah Pugh
15. Birthplace 2 Baltimore, Md

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3/29/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Milton Ave & Rose St.

18 (a) Funeral director Howard N. Bligh Jr.
(b) Address 4914 Belair Road

MAR 28 1948
(Date rec'd by registrar)

(b) Registrar

Waiting for Affidavits, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 26 - 1948, at 9.40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12 - 30 - 1944 to 3 - 26 - 1948, and that I last saw her alive on 3 - 26 - 1948.

Immediate cause of death: Bronchopneumonia — Duration: 2 Wks

Due to:

Due to:

Other Conditions: Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. T. Benford M. D.
Address Balt City Hosp Date signed 3-26-48

VS 152

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G61646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G61646 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution:
St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1643 Covington St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna C. Walega

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Paul Walega

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Dec 1 or 4 1907 08

8. AGE: Years 40 | Months 3 | Days 24 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name PAUL REISS
13. Birthplace GERMANY

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace NOT KNOWN

16 (a) Informant Paul Walega
(b) Address 1643 Covington St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-30-48 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location A. A-6

18 (a) Funeral director Bernard C Hurle
(b) Address 121 E West St

MAR 28 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-25-48 1948, at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-21 1948 to 3-25 1948, and that I last saw her alive on 3-25 1948

	Duration
Immediate cause of death Spontaneous subarach hemorrhage	
Due to	
Due to	
Other Conditions Pleural effusion - right Hypostatic pneumonia	

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

of autopsy: NONE PERFORMED

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Joseph Krejci M. D.
Address 1400 N. Caroline St. Date signed 3-26-48

VS 150

C61647

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

C61647 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 935 WASHINGTON BLVD
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 935 WASHINGTON BLVD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ERSIE DOLCH.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM	WHITE	MARRIED

6 (b) Name of husband or wife WM DOLCH
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB 1 1895

8. AGE: Years	Months	Days	If less than one day
53	1	26	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business —

FATHER
12. Name ? POWELL
13. Birthplace MD

MOTHER
14. Maiden Name DELLA. ?
15 Birthplace MD

16 (a) Informant MRS ERSIE CORNEAL
(b) Address 935 WASH. BLVD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-31-48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location C. A. Co

18 (a) Funeral director Bernard C. Hesler
(b) Address 121 E West St

MAR 28 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 27 1948, at 10 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6th 1947 to Mar. 27 1948, and that I last saw h[illegible] alive on March 27 1948.

Immediate cause of death	Duration
Carcinoma of Breast	8 years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Hales
Address 517 Scott St. Date signed 3/27/48 M.D.

VS 150

G61648

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1310

G61648 Registered No. 51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 51
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 608 N. Spring St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Edwards (Sarah Yates Edwards)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1896

8. AGE: Years 52 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Victoria Va (Town, county, and state)

10. Usual Occupation Laundry Worker

11. Industry or business

MOTHER / FATHER

12. Name unknown

13. Birthplace " "

14. Maiden Name unknown

15. Birthplace " "

16 (a) Informant Thomas Edwards

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 30-1948 (month) (day) (year)

(c) Cemetery or crematory Victoria Cem. Location Tazewell Co Va

18 (a) Funeral director Chas O. Wilson

(b) Address 100 Rhantly Ave

MAR 28 1948 (Date rec'd by registrar) (b) Burlington, W. Virginia

MEDICAL CERTIFICATION 30

20. DATE OF DEATH Mar 26 1948, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-2-1948 to 3-26-1948 and that I last saw h[illegible] alive on 3-26-1948.

Immediate cause of death	Duration
Subarachnoid hemorrhage	3 hrs
Due to hypertensive cardio-vascular disease	
Due to chronic nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Sisson M. D.

Address Johns Hopkins Hosp. Date signed 26 March 48

VS 150

G61649

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 54B

G61649
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St & Rutland Ave.
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2427 Shirley Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ABRAHAM LEVINSON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years [redacted] | Months 2 | Days 2 | If less than one day: hr. min.

9. Birthplace Lith
(Town, county, and state)

10. Usual Occupation Banker

11. Industry or business

FATHER
12. Name Harry Litt
13. Birthplace Lith

MOTHER
14. Maiden Name Toby Litt
15. Birthplace Lith

16 (a) Informant Rose Levinson
(b) Address 2427 Shirley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-48 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Boulevard

18 (a) Funeral director Jacob Levinsohn
(b) Address 2100 Eutaw Place
Huntington Williams, Md.

19 (a) MAR 28 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 28, 1948 at 6:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from MAR 20 1948 to Mar 28, 1948 and that I last saw h[illegible] alive on Mar 28 1948.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Malignant brain tumor	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Mar. 28, 1948

Major findings of operation: Extensive brain tumor

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irvin M. Cushner M. D.
Address Sinai Hospital Date signed 3-28-48

VS 150

X

G61650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G61650 Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2701 Ellicott Dr
(c) Hospital or institution: 16-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2701 Ellicott Drive (If rural give location)
(e) Citizen of foreign country? Cit. (Yes or No)
If yes, name country

3 (a) FULL NAME Walter F. Dunn "Dunn"

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-14-8164

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ida B. Dunn
6 (c) If alive, give age 66 years
7. Birth date of deceased (mo., day, yr.) 9-3-1869
8. AGE: Years 79 | Months 6 | Days 23. | If less than one day: hr. min.
9. Birthplace Croftow, Virginia (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Patchael Dunn
13. Birthplace England

MOTHER
14. Maiden Name Mary M. Jones
15. Birthplace Virginia

16 (a) Informant William F. Dunn
(b) Address 2701 Ellicott Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 29 MAR 48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore City

18 (a) Funeral director F. D. Wiphart & Son
(b) Address 1300 Eutaw Place

MAR 28 1948 (Date rec'd by registrar) Signature for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 26 1948 at 5:28 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1944 to March 26 1948 and that I last saw him alive on 3/25 1948.

Immediate cause of death: Uremia
Cerebral apoplexy
Due to: Arteriosclerosis
Due to: Arteriosclerotic
Other Conditions
(Include pregnancy within 3 months of death)

Duration: 4 days; 4 days; 3 yrs

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. McDermott M. D.
Address 1136 Eutaw Pl Date signed 3/27/48

1136. X

VS 150

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

661651 BC-48-05637

A61485

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1579

Registered No. 661651

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 614 S. Streeper, St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sharon Lou Donnelly.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-14-48

8. AGE: Years | Months | Days: 10 12 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER | FATHER

12. Name John James Donnelly

13. Birthplace Md

14. Maiden Name Dorothy Bakowski

15. Birthplace Md

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 29 48 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Mt. Carmel Dundalk Ave

18 (a) Funeral director Raymond C. Fink

(b) Address 7484 Frankford Ave.

19 (a) MAR 29 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1948 at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-17- 1948 to 3-27- 1948 and that I last saw her alive on 3-27- 1948.

Immediate cause of death: Respiratory distress — Duration: over

Due to: Pneumonia

Due to:

Other Conditions: Trachea-esophageal fistula post-operative

(Include pregnancy within 3 months of death)

Date of operation 3-21-48

Major findings of operation: Trachea-esophageal fistula

of autopsy: Same plus abscess at mediastinum

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lee Mil Rose M. D.

Address Johns Hopkins Hosp Date signed 3-28-48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Type or print plainly, with undrying ink. Every item of information should be carefully supplied.

661652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a.

Registered No. 661652

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4114 Kinsway Ave
(c) Hospital or institution: 27-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4114 Kinsway Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Emma L. Fernheimer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband ~~or wife~~: Samuel L. Fernheimer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 27 1891

8. AGE: Years 56 | Months 8 | Days 0 | If less than one day: hr. min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual Occupation: Own Home

11. Industry or business: Housewife

FATHER
12. Name: Thomas Mahr
13. Birthplace: Md.

MOTHER
14. Maiden Name: Carrie DeLozier
15. Birthplace: Md.

16 (a) Informant: Samuel L. Fernheimer
(b) Address: 4114 Kinsway Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~: Cedar
Location: Washington D.C.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.

19 (a) MAR 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 March 1948 at 4:30 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Cerebral Vascular Accident

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Wm. H. Karnmeyer M.D. Medical Examiner.
Date signed 27 Mar. 1948

VS 181

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

661653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 120B

Registered No. X 661653

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Hanover
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County Balto
(c) City or town Balt. #7 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1914 Kennon Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Godfrey Lucas

3 (b) If veteran, name war: W. W. #1

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Agnes M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 3rd 1889

8. AGE: Years	Months	Days	If less than one day
59	0	24	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Clerical Work

11. Industry or business Custom House

FATHER
12. Name Robt. V. Lucas
13. Birthplace Richmond Va.

MOTHER
14. Maiden Name Mary McGovans
15. Birthplace Md.

16 (a) Informant Mrs Agnes M. Lucas
(b) Address 1914 Kennon Drive

17 (a) Burial (Burial, cremation, or removed) (b) Date thereof 3/31/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1317 St. Paul St

19 (a) MAR 29 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-27 1948, at 5:40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1 1948, to 3-27 1948, and that I last saw h alive on 3-27 1948.

Immediate cause of death	Duration
Cardio respiratory failure	
Due to Peptic ulcer perforation abdominal operation – resection + anastomosis	
Due to Wound dehiscence Drug allergy	
Other Conditions Peritonitis Intestinal Hernia	

(Include pregnancy within 3 months of death)

Date of operation 3-3-48

Major findings of operation: Peptic ulcer perforation + abscess

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ben Gold, M. D.
Address Univ. Hosp. Date signed 3-27-48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G61654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

567

Registered No. G61654

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. Balt. Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 Days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County (Hanover)
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 21 Granger St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Percy Alvirne

3 (b) If veteran, name war —

3 (c) Social Security Account No. 189-07-2791

4. Sex M

5. Color or race W

6 (a) ~~Single, married, widowed, or divorced~~ Married

6 (b) Name of husband or wife Nettie V. Alvirne

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 30 1906

8. AGE: Years 41 | Months 3 | Days 28 | If less than one day hr. min.

9. Birthplace York Co., Pennsylvania (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Roberts & Son - Towson Md

MOTHER / FATHER

12. Name Samuel McElvinie

13. Birthplace Pa

14. Maiden Name Mary Bjum

15. Birthplace Pa.

16 (a) Informant F/S. Wm A. Frings

(b) Address Hanover Pa.

17 (a) Burial (b) Date thereof 3/31/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Root Haven

Location Hanover Pa.

18 (a) Funeral director William Cook Inc.

(b) Address 127 E. Paul St.

19 (a) MAR 29 1948 (b) Huntington W. Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/28/48 19 , at 10 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6 1948 to 3/28 1948, and that I last saw him alive on 3/28 1948.

Immediate cause of death	Duration
Cerebellar failure	
Due to Cerebral edema & coma	
Due to Interventricular bleeding due to Cerebellar Neoplasm (Meningioma	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 3/22/48

Major findings of operation: Meningioma in region of cerebellum

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. A. Gallenkemper M. D.

Address Univ. Hosp. Date signed 3-29-48

G61655

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92B

Registered No. G61655

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3102 Clifton Ave
(c) Hospital or institution: 15-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3102 Clifton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis J Van Blargan

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-24-0274

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Sr

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 2 - 1929

8. AGE: Years 18 | Months 11 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Usher.

11. Industry or business Walbrook Amusement Co

MOTHER / FATHER

12. Name Hoover Van Blargan

13. Birthplace Pa.

MOTHER

14. Maiden Name Sophia Budalewsky

15. Birthplace Poland

16 (a) Informant Hoover Van Blargan

(b) Address 3102 Clifton Ave

17 (a) Burial (b) Date thereof 3/30/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem

Location Balto Md.

18 (a) Funeral director Wm Cook Inc

(b) Address 217 St Paul St

19 (a) MAR 29 1948 (b) Tentative for Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 26 1948, at 12 32 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1947 to Mar 26 1948, and that I last saw him alive on Mar 25 1948.

	Duration
Immediate cause of death: Rheumatic Cardio-vascular disease	8 yrs.
Due to: Cardiac failure	3 wks.
Due to: mitral stenosis and insufficiency	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Daniel R Robinson M. D.

Address 1135 Gurym Belle Place Date signed 3/29/48

061656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 061656

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 328 Westowne Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Dittzel (Ditzel)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Dorothy
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1-10-07
8. AGE: Years 41 | Months 2 | Days 18 | If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Asst. Supt. & Manager
11. Industry or business

FATHER
12. Name Frederick Ditzel
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Eberhart
15. Birthplace Md.

16 (a) Informant Mrs Dorothy E. Ditzel Wife pd.
(b) Address Rad JOHNS HOPKINS HOSPITAL 328 Westowne Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Extended

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 MAR 29 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1948, at 9-52 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 27 1948 to Mar. 28 1948 and that I last saw him alive on Mar. 28 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration 19hrs.
Due to: Hypertension — 10 yrs.
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature JM McCoy
Address John Hopkins Hosp. Date signed 3/28/48

VS 150

Please write plainly, preferably with pen and ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

661657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 661657

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1210 W. Lombard St.
(c) Hospital or institution: 18-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 W. Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas P. Monahan

3 (b) If veteran, name war —

3 (c) Social Security Account No. 246-03-1261A

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married.

6 (b) Name of husband or wife Katherine M.

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1878

8. AGE: Years 69 | Months 3 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Bartender

11. Industry or business Retired

FATHER
12. Name Peter Monahan
13. Birthplace Maryland

MOTHER
14. Maiden Name Bridgett M. ?
15. Birthplace Ireland

16 (a) Informant Mrs Katherine M. Monahan
(b) Address 1210 W. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-29-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Frederick A. Cole
(b) Address 1700 W. Lombard St.

19 (a) MAR 29 1948 (Date received by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25, 1948, at 6:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1946 to Mar 25 1948 and that I last saw him alive on Mar 25 1948

	Duration
Immediate cause of death: Cerebral Hemorrhage Left	3/23/48
Due to Arteriosclerosis	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Carl A. Ross King M. D.
Address 1216 W. Lombard St Date signed 3/26/48

V S 150

The 661658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

Registered No. 661658

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1618 N. Calvert St.
(c) Hospital or institution: 12-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) ~~Length~~ of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 N. Calvert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Owen Francis Kane

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Stella Kane
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 19th 1885

8. AGE: Years	Months	Days	If less than one day
62	6	9	hr. min.

9. Birthplace Providence R.I.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business "

FATHER
12. Name (Unknown) Kane
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Stella Kane
(b) Address 1618 N. Calvert St

17 (a) Removal (b) Date thereof 3/30/48
(Burial, ~~cremation, or~~ removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Pine Grove
Location Berwick Pa.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) MAR 29 1948 (b) Huntingdon Williamsport Md
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 28th 1948, at 12 48 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-2- 1948 to Mch 28- 1948, and that I last saw ~~him~~ alive on Mch 28- 1948.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Carcinoma of Pancreas	8-Month
Due to	
Other Conditions Metastasis in Lungs	2 -

(include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C Gill Wall MD
Address 1631 E. North av Date signed Mch 28-48 M. D.

VS 150

661653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 938

Registered No. 661659

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard & Green St.

(c) Hospital or institution; University Hospital 21-1

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Balto. (b) County

(c) City or town Md. (If outside city or town limits, write RURAL and give town)

(d) Street No. 1028 Maldien St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Kate Smith

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife deceased Joseph Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1887

8. AGE: Years	Months	Days	If less than one day
60	9	22	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Vetter Sr.

FATHER 13. Birthplace Balto. Md.

MOTHER 14. Maiden Name

MOTHER 15. Birthplace

16 (a) Informant Mrs. Mary Taylor

(b) Address 708 W. Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 29/48 (month) (day) (year)

(c) Cemetery or crematory Glen Haven Cemetery

Location Ritchie Highway

18 (a) Funeral director Richard Funeral Home

(b) Address 216 N. Charles St.

19 (a) MAR 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26 1948, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/26 1948 to 3/26 1948, and that I last saw h e r alive on 3/26/48 1948.

Immediate cause of death Coma; respiratory failure

Due to Acute pulmonary edema

Due to Chronic hypertension arteriosclerotic CVD.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Earl L. Rogers, M.D.

Address Baltimore County Hosp. Date signed 3/27/48

VS 150

Earl L Rogers M.D.

661660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8-30a

Registered No. 661660

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 134 Augusta Ave.

(c) Hospital or institution: 20-8

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 134 D. Augusta Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mary V. Kennedy

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Wm. J. Kennedy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-28-1860

8. AGE: Years	Months	Days	If less than one day
87	8	28	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name James Ryan

13. Birthplace Ireland

MOTHER

14. Maiden Name Unknown

15. Birthplace Ireland

16 (a) Informant Mrs. Frances E. Kennedy

(b) Address 134 S. Augusta Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Old Frederick Road

18 (a) Funeral director A. E. Krause

(b) Address 216 S. Charles St

19 MAR 29 1948 (Date rec'd by registrar) (b) Hunting for Wm. Register

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1948, at 1125 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1943 to 3/26 1948 and that I last saw h alive on 3/28 1948

Immediate cause of death: Gangrene Both feet and Legs

Due to Senile Arteriosclerosis

Due to

Other Conditions Cerebral Hemorrhage

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 1 1/2 48; 6 yrs; 8/14/48

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Elliot W. Johnson M. D.

Address 3432 Druid Park Ave Date signed

VS 150

97

G61661

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G61661

186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore 2-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 837 W Cross St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellwood D. Buckmaster

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-03-3897-A

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Emma Ruth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-7-1882

8. AGE: Years 66 | Months - | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Anne Arundle County
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John R Buckmaster
13. Birthplace Ann Arundle County

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs Catherine Beangle
(b) Address 837 W Cross St # 30

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-29-48 (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cemetery
Location Putaline Highway.

18 (a) Funeral director Walter F Schwiersberg
(b) Address 112 & West Cross St # 30

19 (a) MAR 29 1948 (Date rec'd by registrar) (b) Funeral for Buckmaster, M.H.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1948, at 5:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH fracture
dislocation 5th Cervical
vertebrae & injury Cord

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 21/2

(a) Date of injury March 24/48 5:00 P.M.
(b) Where did injury occur? 837 W. Cross St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fall-stairs

23. Signature Earl L Ryan M.D.
Medical Examiner.
Date signed 3-26-48

VS 131

ATE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The is especially important. Physicians: please write the causes of death clearly and legibly.

C61662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C61662

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1312 N. Broadway
(c) Hospital or institution: 8.7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARRIE P. LANTZ

3 (b) If veteran, name war: No

3 (c) Social Security Account No. none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles P. Lantz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1864

8. AGE: Years 83 | Months 6 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Burnett
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Chason
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Naomi M. Lantz
(b) Address 1312 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30.48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) MAR 29 1948 (Date received by registrar) (b) Registrar's signature for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 1948, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1946, to Mar 26 1948, and that I last saw h[er] alive on Mar 25 1948

Immediate cause of death
Coronary Thrombosis — Duration: 1
Due to Arteriosclerosis — Duration: One Years
Due to — Duration: Unk
Other Conditions Myocardial Degeneration — Duration: Yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Rice M. D.
Address 24 S. Mon Date signed Mar. 27/48

X

661663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

Registered No. 661663

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 15-1
(b) Street address
(c) Hospital or institution: Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1536 Leslie St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John A. BROOKS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14 1888

8. AGE: Years 59 Months 11 Days 11 less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER 12. Name John Brooks

13. Birthplace Md.

MOTHER 14. Maiden Name Mamie Harris

15. Birthplace Md.

16 (a) Informant Mrs Margaret Brooks

(b) Address 1536 Leslie St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/48 (month) (day) (year)

(c) Cemetery or crematory St. Peters

Location Balto. Md.

18 (a) Funeral director Mrs Lucy A. Hollamon

(b) Address 1621 Druid Hill Ave

19 (a) MAR 29 1948 (Registered by registrar) (b) Huntingtown Williamsport Md (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25/48, at 8:30 a.m. P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed 3/25/48

VS 151

X

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1170

Registered No. 661664

661664

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 19-1
(c) Hospital or institution: 426 N. Carey St
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 426 N. Carey St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Albert Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Eva Adams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4-1898

8. AGE: Years	Months	Days	If less than one day
49	9	21	hr. min.

9. Birthplace Phila. Pa. (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " " "

MOTHER
14. Maiden Name Unknown
15. Birthplace " " "

16 (a) Informant Eva Adams
(b) Address 426 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-29-48 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Balto. Co.

18 (a) Funeral director Samuel W. Sullivan
(b) Address 1011 N. Arlington Ave Reisterstown, Md.

19 (a) MAR 29 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-24 1948, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-12 1948 to 3-24 1948 and that I last saw h[illegible] alive on 3-24 1948

Immediate cause of death Secondary Anemia — Duration —

Due to Bleeding Peptic Ulcer

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Peptic Ulcer

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Franklin Phillips M. D.

Address 1543 Penna. Ave Date signed 3/27/48

VS 150

X

G61665

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G61665

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5112 Windsor Ave.
(c) Hospital or institution: 15-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3112 Windsor Ave.,
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Ludmila Klima

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	separated

6 (b) Name of husband or ~~wife~~ Vincent Klima
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1885

8. AGE: Years	Months	Days	If less than one day
62	7	18	hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Frank Kreisinger
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Marie Tecl
15 Birthplace Czechoslovakia

16 (a) Informant Mrs. Goldie Riha - daughter
(b) Address Ferndale, Maryland.

17 (a) Burial (b) Date thereof 3/29/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc
(b) Address 2601-3-5 E. Madison Street

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MAR 29 19[illegible]
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1948, at 4 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 2 1948 to March 25 1948 and that I last saw h[illegible] alive on March 24 1948

Immediate cause of death Myocarditis — Duration 4 mo.
Due to Arteriosclerosis — ?
Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter L Dublett M. D.
Address 222 Garrison Blvd Date signed March 27/48

661666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93E

Registered No. 661666

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11-3
(c) Hospital or institution: Balto. City Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 439 Orchard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Sasser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1 1917

8. AGE: Years 30 | Months 4 | Days 24 | If less than one day hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Lewis Sasser
13. Birthplace N.C.

MOTHER
14. Maiden Name Mamie Schuffer
15. Birthplace N. C.

16 (a) Informant: Carl Sasser
(b) Address Snow Hill N.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29 48 (month) (day) (year)

(c) Cemetery or crematory
Location Wilson N.C.

18 (a) Funeral director A. Halstead
(b) Address 918 Kenilworth Ave

19 MAR 29 1948 (Date rec'd by registrar) (b) Funeral Home Washington Blvd.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1948, at 11:50 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Acute Congestive Heart Failure

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Royer M.D.
(Medical Examiner)

Date signed 26 Mar 48

VS 151

G61667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 61

Registered No. G61667

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto Co. Parrs Pt.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2428 Lodge Farms Road
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4-22-30

8. AGE: Years 17 | Months 11 | Days 4 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Philip Jones
13. Birthplace Va

MOTHER 14. Maiden Name Mary Tureal
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Balto Co, Md

18 (a) Funeral director Robt S Williams
(b) Address 1545 N Mc Elderry St

19 (a) MAR 29 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1948, at 10 A M

21. I certify that death occurred on the date above stated: that I attended deceased from 3-25-1948 to 3-26-1948, and that I last saw him alive on 3-26-1948.

Immediate cause of death: Diabetic Acidosis — Duration: 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas E. Van Metre M.D.
M. D.
Address Johns Hopkins Hosp Date signed

BC-C 84777

661668

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 182a

Registered No. 661668

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4-2
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 658 W. Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Armond Smith, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1947

8. AGE: Years | Months 8 | Days 29 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Armond Smith
13. Birthplace D.C.

MOTHER
14. Maiden Name Annie Brashay
15. Birthplace D.C.

16 (a) Informant Armond Smith Sr.
(b) Address 658 Fairmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-48 (month) (day) (year)
(c) Cemetery or crematory
Location Mt Calvary

18 (a) Funeral director A. Halstead
(b) Address 918 Penna Ave

19 (a) MAR 29 1948 (Date rec'd by registrar) (b) Interment in Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1948 at 2:05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Mechanical suffocation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-27-48 at 1:30 A.M.
(b) Where did injury occur? 658 W. Fairmont Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Bedclothes

23. Signature [signature] M.D. Medical Examiner
Date signed 3-27-48

VS 151

G61669
AB-118380

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 937

G61669
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) 43yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 636 George Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Winfield

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Married

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10-1867

8. AGE: Years	Months	Days	If less than one day
80	11	15	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Abby?
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3-30-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary.
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Lemmon Street

19 (a) MAR 29 1948 (b) Huntington Woollcutt, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25- 1948, at 8.50PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-23- 1948, to 3-25- 1948, and that I last saw him alive on 3-25- 1948.

Immediate cause of death	Duration
Respiratory failure	
Due to Bilateral Hydrothorax	
Due to ? Neoplasm	
Not seen in gross on autopsy	
Other Conditions Arteriosclerotic heart disease. Prolapse of rectum	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. T. Benford M. D.
Address Balt. City Hosp. Date signed 3-26-48

X

661670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 661670

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens
(c) Hospital or institution: St. Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2224 Rock Hall Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Minnie Reedy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

(b) Name of husband or wife Edmund L.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10/4/1885

8. AGE: Years	Months	Days	If less than one day
62 61 yr.	5	20 21	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John E. Norwood
13. Birthplace Md.

MOTHER
14. Maiden Name Clementine Cartill
15. Birthplace Md.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-29-48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Fulton & Fayette Sts

19 (a) MAR 29 1948 (Date rec'd by registrar) (b) Interring for Baltimore, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25/1948, at 10:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17 1948 to 3/25 1948 and that I last saw her alive on 3/25 1948.

Immediate cause of death Congestive heart failure

Due to Old rheumatic heart disease with mitral stenosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation none performed
Major findings of operation:
of autopsy: Rheumatic heart disease

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert D. Luckas, M.D.
Address St Agnes Hosp Date signed 3/25/48

VS 130

G61671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G61671

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W Fayette St
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Cecil
(c) City or town Calvert Ville (If outside city or town limits, write RURAL and give town)
(d) Street No 6106 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Patrick J. Kennedy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
M	W	

6 (b) Name of ~~husband or~~ wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17 188[illegible]

8. AGE: Years	Months	Days	If less than one day
67	8	9	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Fishing Station
11. Industry or business Grocer

FATHER
12. Name John Kennedy
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Mortagh
15. Birthplace Ireland

16 (a) Informant Mrs P J Kennedy
(b) Address 6106 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Cecil Md

18 (a) Funeral director George E Kerling
(b) Address Fulton & Fayette

19 (a) MAR 29 1948 (Date rec'd by registrar) (b) Registrar Washington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 March 1948, at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 25 Feb 1948 to 26 March 1948 and that I last saw him alive on 26 March 1948.

Immediate cause of death	Duration
Carcinoma, papillary, of Urinary bladder	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph R Liberto M. D.
Address Bon Secours Hosp. Date signed 3/26/48

VS 150

C61672

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. C61672

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Sorrento Rd
(c) Hospital or institution Colonial Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 108 E 25th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Ozello B Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Charles H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20 1863

8. AGE: Years 85 | Months 0 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Co Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name James Long Bennett

13. Birthplace Md

MOTHER 14. Maiden Name Lydia Ewing Bedden

15. Birthplace Md

16 (a) Informant Mrs Edwina A Lindsay

(b) Address 2307 N Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/48 (month) (day) (year)

(c) Cemetery or crematory St James Church

Location Mt Lady Manor Md

18 (a) Funeral director Wilbur Chase

(b) Address 1217 N Gay St

19 MAR 29 1948 (Date rec'd by Registrar) Watkins Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1948, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 14 1948, to March 28 1948, and that I last saw h-e alive on March 28 1948.

Immediate cause of death	Duration
Bronchopneumonia	3 days
Due to	
Due to	
Other Conditions Senility arteriosclerotic cardiovascular disease	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Carl L Rose M. D.

Address 142 Westonia Place Date signed 3-29-48

VS 150

107

661673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. 661673

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 17-1
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 410 N Pearl Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MORRIS McDANIELS (Maurice McDaniels)

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-1310

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Cassi

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1894

8. AGE: 53 Years 6 Months Days If less than one day hr. min.

9. Birthplace Illinois (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Wm McDaniels
13. Birthplace Illinois

MOTHER
14. Maiden Name Georgiana Coates
15. Birthplace Calvert Co. Md.

16 (a) Informant Mr. McDaniels (brother)
(b) Address 708 Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/48 (month) (day) (year)
(c) Cemetery or crematory W.F. Curtis Cem
Location

18 (a) Funeral director Wm Katze & Williams
(b) Address 332 W. Lexington St

19 (a) MAR 29 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26/48 19 at 9:00 A.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D. (Medical examiner.)
Date signed 3/26/48

VS 151

661674

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 83a

Reg. Dist. No.

661674

1. PLACE OF DEATH: County ... City or town Baltimore (If outside city or town limits, write RURAL and give nearest town) 501 Wellington ave md

How long in above place of death? 20.5

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County ...

City or town Baltimore (If outside city or town limits write RURAL and give nearest town)

Street No. 501 Wellington ave (If rural, give LOCATION)

2.(a) If veteran, name war ...

3. (a) FULL NAME Eleonora Mary Kelly

3. (b) Social Security Number

4. Sex: female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife: John A. Kelly

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Sept 2-1866

8. AGE: Years 84 Months 5 Days 24 If less than one day ... hrs. ... min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Ludwig M. Wolcott

13. Birthplace: Germany

MOTHER 14. Maiden name: Mary Slade

15. Birthplace: Germany

16. Interment: John A. Kelly

Address: 2015 Hollins St

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 30-48 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: old Frederick Rd Balto md

18. Funeral director: Bernard G. Fink

Address: 3603 Boland Rd

19. MAR 29 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 March 1948 at 11:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 March 1948 to 26 March 1948 and that I last saw her alive on 25 March 1948

Immediate cause of death: Bronchopneumonia — DURATION: 3 days

Due to: Cerebral Hemorrhage — 6 days

Due to: Generalized Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE H H Baylus M.D. (M. D. or other)

Address 1600 Wilkens Ave Date signed 27 Mar 48

B.C. C 72969 G61675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. G61675

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15-6
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Ducto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2723 Treasbury Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Edward Buckley

3 (b) If veteran, name war F

3 (c) Social Security Account No.

4. Sex Male | **5. Color or race** White | **6 (a) Single, married, widowed, or divorced** S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-5-47

8. AGE: Years 1 | Months 0 | Days 24 | If less than one day ___ hr. ___ min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Doyle Buckley
13. Birthplace W. Va.

MOTHER
14. Maiden Name Elma Hurtt
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 3-29-48 (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Taylor Ave Balto Co

18 (a) Funeral director J. Howard Strong
(b) Address 3207 W. North Ave

19 (a) MAR 29 1948 (Date rec'd by registrar) **(b)** waiting for Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26 1948, at 4:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-20-1948 to 3-26-1948, and that I last saw him alive on 3-26-1948.

Immediate cause of death cardiac decompensation — Duration 8 hrs

Due to Congenital Heart Disease — Duration 1 yr

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3/25/48

Major findings of operation: Transposition Great Vessels

of autopsy: Single Ventricle

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James R. Cantrell M.D.
Address The Johns Hopkins Hosp **Date signed** 3/26/48

VS 150

G61676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G61676

SC-48-0312 ✓157E

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MD GEN. HOSP 23-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 50
(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 S. CHARLES ST (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH KATHERYN WASHBURN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 7, 1948

8. AGE: Years	Months	Days	If less than one day
0	1	21	\ hr. \ min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation INFANT

11. Industry or business

FATHER
12. Name CHARLES WASHBURN
13. Birthplace WISCONSIN

MOTHER
14. Maiden Name DOROTHY LOU HAMILTON
15. Birthplace ILLINOIS

16 (a) Informant MOTHER
(b) Address 1301 S. CHARLES ST

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 3-29-48 (month) (day) (year)
(c) Cemetery or crematory St. Mary's - Hampden
Location Roland Ave.

18 (a) Funeral director F. G. Coney & Son
(b) Address 120 E. Hart Ave.

19 MAR 29 1948 (Date rec'd by registrar) Cremation Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR 28 1948, at 11:16 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7 FEB 1948, to 28 MAR 1948, and that I last saw her alive on 28 MAR 1948.

Immediate cause of death Congenital Heart. — Duration 50 days.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Congenital Heart

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert D. Schoenbucher, M.D.
Address Med. Federal Hosp Date signed 29 Mar 48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

061677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 061677

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1605 Aliceanna Street
(c) Hospital or institution: Home 2-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 31,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Aliceanna Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Mach (Or) Mack

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband ~~or wife~~ George Mach
6 (c) If alive, give age Deceased years

7. Birth date of deceased (mo., day, yr.) July 16-1891

8. AGE: Years	Months	Days	If less than one day
56	8	12/3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Golembieski
13. Birthplace Poland

MOTHER
14. Maiden Name Catherine Siwak
15. Birthplace Poland

16 (a) Informant Mary Lampke (Daughter)
(b) Address 1100 N. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore, Md.

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street

19 (a) MAR 29 1948 (Date rec'd by Registrar) (b) Entering for Williams, M.D. Address 448 N. Eutaw Ave

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29th 1948, at 12.55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-5- 1946 to 3-29- 1948, and that I last saw h[illegible] alive on 3-28- 1948.

	Duration
Immediate cause of death: Coronary occlusion	1/2 hr.
Due to: Hypertensive C-V disease	2 years
Due to:	
Other Conditions: Bronchial asthma	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benj. B. Jones M.D. M. D.
Address 448 N. Eutaw Ave Date signed 3-29-48

V S 150

X

C61678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. C61678

C M. 103612

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Year
(e) Length of stay in Baltimore (yrs., mos., or days) 44 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County [illegible]
(c) City or town Edgewood
(If outside city or town limits, write RURAL and give town)
(d) Street No. Edgewood Arsenal
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Tamulonis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 2- 1879

8. AGE: Years	Months	Days	If less than one day
68	6	22	hr. min.

9. Birthplace Lithunia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Tamulonis
13. Birthplace Lith.

MOTHER
14. Maiden Name Alice ?
15. Birthplace Lith.

16 (a) Informant Records B lto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3-29-49
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Belair Rd

18 (a) Funeral director Joseph Kaminsky Sons
(b) Address 69 Washington Blvd

19 (a) MAR 29 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 24 - 1948, at 6.00A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 - 9 - 1946, to 3 - 24 - 1948 and that I last saw him alive on 3 - 24 - 1948

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic heart disease	
Due to	
Other Conditions Malnutrition	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. T. Binford M. D.
Address Balt. City Hosp Date signed 3-26-48

VS 150

T

661679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124B

Registered No. 661679

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 2-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 225 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1718 E. Lombard St.
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Norway

3 (a) FULL NAME EVEN ASBJOR FREMSTAD

3 (b) If veteran, name war --

3 (c) Social Security Account No. 129-14-4308

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 9, 1897

8. AGE: Years	Months	Days	If less than one day
50	3	14	hr. min.

9. Birthplace Oslo, Norway
(Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Seafarer

FATHER
12. Name Andreas Fremstad
13. Birthplace Norway

MOTHER
14. Maiden Name Colina ?
15. Birthplace Norway

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof 3/29/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemy.
Location Woodlawn, Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) MAR 29 1948 Huntington Williams, M.D.
(Filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1948, at 4:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 11 1947 to Mar. 23 1948 and that I last saw him alive on Mar. 23 1948.

Immediate cause of death	Duration
Cirrhosis of liver with ascites	unknown
2-Arteriosclerotic cardio-	
~~xxxx~~ vascular disease	unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surg. M.D.
Address Clinical Director Date signed 3-27-48
U S Marine Hospital

VS 150

G61680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 131a

Registered No. G61680

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT ST.
(c) Hospital or institution: MERCY HOSP
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 65 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town BALTIMORE (If outside city give township, village or borough)
(d) Street No. 2701 GLENMEADE AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3. (a) FULL NAME CONRAD J KREINER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife RITA M. KREINER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT 1, 1877

8. AGE: Years	Months	Days	If less than one day
70	5	27	hr. min.

9. Birthplace GERMANY (Town, county, and state)
10. Usual Occupation UNEMPLOYED
11. Industry or business

FATHER
12. Name SIMON KREINER
13. Birthplace GERMANY

MOTHER
14. Maiden Name KATHRYN ?
15. Birthplace GERMANY

16 (a) Informant ADM. SLIP
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof MAR 28 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director Mamie Cook Syfer
(b) Address 1600 W. North Ave.

19 (a) MAR 29 1948 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/28 1948 at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/28 1948 to 3/28 1948, and that I last saw h[illegible] alive on 3/28 1948

Immediate cause of death CARDIO-RESP. FAILURE — Duration

Due to HYPERTENSIVE CV. RENAL DISEASE

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: HYPERTROPHIED HEART

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elden H. Pierce
Address Mercy Hosp Date signed 3/28/48

VS 190

661681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 661681

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lorman Redwood
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Elliott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. College Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Milton Easton (Milton Henry Easton)

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Grace L. Easton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May-14-1875

8. AGE: Years 72 | Months 10 | Days 13 | If less than one day: hr. min.

9. Birthplace Elliott City-Md.
(Town, county, and state)

10. Usual Occupation Funeral Director

11. Industry or business Mortuary

MOTHER / FATHER

12. Name Moses Clinton Easton

13. Birthplace Howard Co. Md.

MOTHER

14. Maiden Name Annie Laumann

15. Birthplace Howard Co. Md.

16 (a) Informant Clinton M. Easton (Son)

(b) Address Elliott City-Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar-30-48 (month) (day) (year)

(c) Cemetery or crematory St John's

Location Elliott City-Md.

18 (a) Funeral director: Stuart Mowbray Co.

(b) Address 108 W North Ave.

19 (a) MAR 29 1948 (Date rec'd by registrar) (b) Lexington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/27 1948, at 11:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/23 1947, to 3/27 1948, and that I last saw h[illegible] alive on 3/27 1948.

Immediate cause of death CVD — Duration 4 days

Due to Arteriosclerosis

Due to Angina

Other Conditions Bronchial Asthma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R A Neubauer, M.D.

Address Univ Hosp. Date signed 7/27/48

G61682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (1937)

Registered No. G61682

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ✓
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: Blue Detour Institute
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-3-12
(e) Length of stay in Baltimore (yrs., mos., or days) 4-3-12

2. USUAL RESIDENCE OF DECEASED:
(a) State Connecticut (b) County
(c) City or town Hartford
(If outside city or town limits, write RURAL and give town)
(d) Street No. 160 Farmington Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sister Mary Brendan Tracy

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife: Single
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 27 1875

8. AGE: Years 72 | Months 6 | Days 12 | If less than one day: hr. min.

9. Birthplace Hinchbrook, Prov. of Quebec, Canada (Town, county, and state)

10. Usual Occupation Religious Sister

11. Industry or business

FATHER
12. Name Andrew Tracy
13. Birthplace Hinchbrook Prov. of Quebec

MOTHER
14. Maiden Name Maria McCann
15. Birthplace Thompsonville, Connecticut

16 (a) Informant Blue Detour Institute
(b) Address 6420 Reisterstown Road Baltimore 15, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-29-48 (month) (day) (year)

(c) Cemetery or crematory St Mary's
Location Hartford Conn

18 (a) Funeral director Edward Morrow Co.
(b) Address 108 W Monk Ave.

19 (a) MAR 29 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28th 1948, at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 16th 1948, to March 2 1948, and that I last saw her alive on March 28 1948.

Immediate cause of death: Cardio vascular Collapse.
of two days duration

Due to:

Due to:

Other Conditions Senile Dementia

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dominic P. Magaw M. D.
Address 336 Jordan Ave. Date signed

G61683 RC-48-00338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 182a

Registered No. G61683

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2208 Westwood Avenue
(c) Hospital or institution: 15-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2208 Westwood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Janet Weingarten

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/3/48

8. AGE: Years	Months	Days	If less than one day
	2	25	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Herbert
13. Birthplace Newfork

MOTHER
14. Maiden Name Gertrude
15. Birthplace Newyork

16 (a) Informant Herbert Weingarten
(b) Address 2208 Westwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-29-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philp Rd Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 240 Ontario Place

19 (a) MAR 29 1948 (Date rec'd by registrar) (b) Registrar Huntington Woods, Mich

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1948, at 4 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Death death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH mechanical suffocation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-28-48 at ? 15/3 P.M.
(b) Where did injury occur? 2208 Westwood Ave
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Probably bedclothes

23. Signature Herbert J. Weingarten M.D. Medical Examiner.
Date signed 3-29-48

VS 191

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C61684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √95c

Registered No. C61684

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St

(c) Hospital or Institution: Lenau 6-3

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 15 No Chester St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bessie Goden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) B 91

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name not known

13. Birthplace Russia

MOTHER 14. Maiden Name not known

15. Birthplace Russia

16 (a) Informant Alan Goden

(b) Address 15 No Chester St

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 3-29-48 (month) (day) (year)

(c) Cemetery or crematory Lozedale

Location Philay Rd + Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 220 Eutaw Place

19 (a) MAR 29 1948 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/28/48 19 , at 1.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1941 to 3/28 1948, and that I last saw her alive on 3/28/48 19

Immediate cause of death	Duration
Cerebral Hemorrhage	4 hours
Due to Hypertension	8 years
Due to Cardiac Hypertrophy	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Theodore Cooper M. D.

Address 220 Eutaw Place Date signed 3/28/48

VS 150

THEODORE Cooper

G61685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G61685

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3010 Tioga Pkwy
(c) Hospital or institution: 15-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3010 Tioga Pkwy
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY GOLDSTINE

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-0604

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife BESSIE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Balto MD
(Town, county, and state)

10. Usual Occupation INS. AGENT

11. Industry or business

FATHER
12. Name HYMAN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name ESTHER
15. Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-48 (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location Phila. Pa.

18 (a) Funeral director VOLK LEWIS INC
(b) Address 2100 Eutaw Pl.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 29 1948

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1948, at 10:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 27 1948 to March 28 1948, and that I last saw h alive on March 28 1948

Immediate cause of death Coronary Thrombosis — Duration 8 hrs

Due to Coronary Heart Disease — 3 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Philip J. Lerner

Address 2401 N. North Ave. Date signed 3/29/48

C61686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. C61686

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 16-7
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ---
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2927 Winchester Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John H. Koller

3 (b) If veteran, name war: None

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Lizzie J. Koller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 11th 1863

8. AGE: Years	Months	Days	If less than one day
84	3	17	hr. min.

9. Birthplace: Glen Rock, Md. (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business: Penna R. R.

FATHER
12. Name: Samuel Koller
13. Birthplace: Penna

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Penna

16 (a) Informant: Mrs Lizzie J. Koller
(b) Address: 2927 Winchester Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: March 31-1948 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Wm. J. Tickner & Sons.

18 (a) Funeral director: North & Penna Aves.
(b) Address

19 (a) MAR 29 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/28 1948, at 2.25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-31 1947 to 3/28 1948 and that I last saw h.e alive on 3/28 1948.

	Duration
Immediate cause of death: Resp Failure	1 1/2 days
Due to: H+ Failure	
Due to: Arter (CVD)	
Other Conditions: Cancer	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Cancer
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: H. H. Neuhauser, M.D. M. D.
Address: [illegible] Date signed 3/28/48

X

VS 150

C61687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. C61687

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3517 Liberty Heights 15-8
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3517 Liberty Heights (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FERDINAND C. LINK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife LILLIE LINK

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 3, 1871

8. AGE: Years 77 | Months 2 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace BALTO (Town, county, and state)

10. Usual Occupation PHYSICIAN

11. Industry or business —

FATHER 12. Name PHILIP LINK

13. Birthplace GERMANY

MOTHER 14. Maiden Name UNKNOWN

15. Birthplace "

16 (a) Informant MRS LILLIE LINK

(b) Address 3517 LIBERTY HGTS AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/31/48 (month) (day) (year)

(c) Cemetery or crematory LORRAINE

Location BALTO CO. MD

18 (a) Funeral director WM T. TICKNER & SONS

(b) Address BALTO, MD

19 (a) MAR 29 1948 (Date rec'd by registrar) (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/28/48 19..., at 11:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Evans M.D. Medical Examiner.

Date signed 3/28/48

X

C61688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 152

Registered No. C61688

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore CARNEY (If outside city or town limits, write RURAL and give town)
(d) Street No. 9633 Dixon Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Gilbert G. BURNHAM

3 (b) If veteran, name war No
3 (c) Social Security Account No. 213-05-3954

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Harriet Burnham
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Dec 6, 1892

8. AGE: Years	Months	Days	If less than one day
55	3	22	..... hr. ..... min.

9. Birthplace Baltimore Maryland. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Continental Oil Co.

FATHER
12. Name Walter E. Burnham.
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Gielon
15. Birthplace Ireland.

16 (a) Informant MRS. HARRIETTE BURNHAM
(b) Address 9633 Dixon Ave CARNEY MD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/1/48 (month) (day) (year)
(c) Cemetery or crematory PARKWOOD
Location BALTo Co. MD.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address BALTO. MD.

19 (a) MAR 29 1948 (Date rec'd by registrar) Lucretia for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/28 1948, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/22 1948 to 3/28 1948, and that I last saw h. alive on 3/28 1948.

Immediate cause of death	Duration
Cardiac failure due to overwhelming septicemia	
Due to from diffuse cellulitis of face after tooth extraction	10 days.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Incision & Drainage
Major findings of operation: on 3/26/48
of autopsy: None attempted

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry V. Chase M. D.
Address Mercy Hospital Date signed 3/28/48

G61689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 94a

Registered No. G61689

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 12-3
(b) Street address CALVERT & 33RD Sts.
(c) Hospital or institution: UNION MEMORIAL HOSP. D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County .....
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2408 N. CALVERT ST. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Charles H. Sapp

3 (b) If veteran, name war No

3 (c) Social Security Account No. No

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of ~~husband~~ or wife ANNIE G. SAPP. NEE WAGNER

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MAY 20, 1865

8. AGE: Years 82 | Months 10 | Days 8 | If less than one day ..... hr. ..... min.

9. Birthplace BALTO., MD. (Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business .....

FATHER
12. Name JACOB SAPP
13. Birthplace MD.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace "

16 (a) Informant Miss LILLIAN C.R. WAGNER (NIECE)
(b) Address 2408 N. CALVERT ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/30/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ LOUDON PK
Location BALTO., MD

18 (a) Funeral director WM. T. LICHNER & SON
(b) Address BALTO., MD.

19 (a) MAR 29 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 March 1948, at 1 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to .....

Other Conditions Lymphedema, lower ext. leg. (Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Wm. H. Kammer Jr. M.D. Medical Examiner.
Date signed 28 Mar. 48

VS 151

Dr. Sawyer

G61690

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 95B

Registered No. G61690

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2820 Pinewood Avenue
(c) Hospital or institution: 27-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2820 Pinewood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Harry T. H. Sadler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife: Mary
6 (c) If alive, give age 189 years

7. Birth date of deceased (mo., day, yr.) June 6, ~~1898~~ (58)

8. AGE: Years	Months	Days	If less than one day
51 (58)	9	20	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business

FATHER
12. Name: John W. Sadler
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Frances Eagen
15. Birthplace: Baltimore

16 (a) Informant: Mrs. Mary Sadler
(b) Address: 2820 Pinewood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-29-48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Baltimore, Md.

18 (a) Funeral director: Leonard J. Ruck
(b) Address: 5305 Harford Road, #14

19 (a) MAR 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26th 1948, at 3-30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1946, to Mar. 26 1948, and that I last saw h/ll alive on Mar. 26 1948.

Immediate cause of death: Rheumatic Heart Disease — Duration: 10 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: George Sawyer M. D.
Address 4808 Harford Rd. Date signed 3/26/48

VS 153

G61691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 170 c

Registered No. G61691

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12-3
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) dos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 204 E. Ware St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James (Judd) Wills

3 (b) If veteran, name war: W.W. 1

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: m

6 (b) Name of husband or wife: Della

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 | 11 | 1890

8. AGE: Years 57 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation laborer

11. Industry or business

FATHER 12. Name Porter Wills

FATHER 13. Birthplace md

MOTHER 14. Maiden Name →

MOTHER 15. Birthplace md

16 (a) Informant Della Wills

(b) Address 205 Ware st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 | 30 | 48 (month) (day) (year)

(c) Cemetery or crematory Balto Nat

Location md

18 (a) Funeral director Hez. A. Nelson

(b) Address 1303 Pennsylvania Ave

MAR 29 1948 (Date rec'd by registrar)

Remarks: for Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1948, at 8:15 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH: Intracranial hemorrhage

Due to: Lacerations of chin and neck. Fracture of right tibia and fibula.

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 3-26-48 at 8:00 12/7 P M.

(b) Where did injury occur? 2400 Blk. Harford St.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no

(d) Means of injury: Pedestrian struck by auto

23. Signature George L. Merrill M.D. Medical Examiner.

Date signed 3/27/48

X

E PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The especially important. Physicians: please write the causes of death clearly and legibly.

BC-GP3556
G61692

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 33B

✓ G61692 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 21-0r
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1154 Cleveland St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

✓

3 (a) FULL NAME Gerald Stallmon
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single.

6 (b) Name of husband or wife
6 (c) If alive, give age ✓ years
7. Birth date of deceased (mo., day, yr.) July-11-1947.

8. AGE: Years	Months	Days	If less than one day
—	8	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Infant.
11. Industry or business

FATHER
12. Name Charles Stallmon
13. Birthplace 1154 Cleveland St.

MOTHER
14. Maiden Name Ruth Broeckleir
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Ruth L. Stallmon.
(b) Address 1154 Cleveland St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof March 30/48. (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location

18 (a) Funeral director Charles J. Schwab.
(b) Address 3512-Frederick, Ave.

19 (a) (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

MAR 29 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-27-48 19 , at 9:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-25 19 48 to 3-27 19 48, and that I last saw him alive on 3-27 48 19 .

Immediate cause of death	Duration
(a) Vital centers & Circulatory	
(b) respiratory failure	
Due to (c) Fracture of skull, increased intracranial pressure & Shock	
Due to (d) Influenzal Meningitis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Halpin M. D.
Address University Hosp. Date signed 3-27-48

X

C61693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

Registered No. C61693

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 18-2
(b) Street address
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1215 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marion Giles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Lucreasa Giles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 18-1911

8. AGE: Years 36 | Months 7 | Days 6 7 | If less than one day hr. min.

9. Birthplace Sand Spring S C (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William [illegible]
13. Birthplace S C

MOTHER
14. Maiden Name Josey Giles
15. Birthplace S C

16 (a) Informant Lucreasa Giles
(b) Address 1215 W Lexington st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-29-48 (month) (day) (year)
(c) Cemetery or crematory Druid Hill
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna Ave

19 (a) MAR 29 1948 (Date rec'd by registrar) (b) Lexington for Baltimore Md Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-25- 1948 at 5 50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Hms death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of chest

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was ~~primary~~ ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/25/48 at 5 30 P. M.
(b) Where did injury occur? 521 N. Fremont Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Tavern (Public) While at work? No
(d) Means of injury Gunshot

23. Signature [signature] Medical Examiner M.D.
Date signed 3/26/48

X

661694

HEALTH DEPARTMENT—CITY OF BALTIMORE

661694

95c

CERTIFICATE OF DEATH

26 - 3 Registered No.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3541 Cliftmont ave St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME VERONICA ZUCHOWSKA

If U. S. Veteran specify WAR

(a) Residence: No. 3541 CLIFTMONT AVE. St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

3a. If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Zuchowski

6. DATE OF BIRTH (month, day, year) 1882

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. none

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Poland

FATHER

13. NAME Frank Materzyk

14. BIRTHPLACE (city or town) (State or country) Poland

MOTHER

15. MAIDEN NAME Ann Krawczyk

16. BIRTHPLACE (city or town) (State or country) Poland

17. INFORMANT Mrs. Mary Baginska

(Address) 3541 Cliftmont ave

18. BURIAL, CREMATION, OR REMOVAL

Place Holy Rosary cem. Date March 30 1948

19. UNDERTAKER John M. Weber

(Address) 401 S. Chester Street

20. FILED MAR 29 1948 Huntington Williamsport

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) MARCH 26, 1948

22. I HEREBY CERTIFY, That I attended deceased from MARCH 3, 1948, to MARCH 26, 1948

I last saw h alive on MARCH 26, 1948. Death is said to have occurred on the date stated above, at 6.30 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
CORONARY THROMBOSIS	MARCH
CARDIAC DECOMPENSATION	2
CORONARY SCLEROSIS	

Other contributory causes of importance:

Was an operation performed? NO Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? NO If so, specify

(Signed) John F. Polak, M. D.

(Address) 4200 Sheldon Avenue

VS 3

X

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dr. P. Flynn

G61695

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. G61695

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 444 East 22nd Street
(c) Hospital or institution: 12-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 444 East 22nd Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME KATHERINE O'HALLORAN

3 (b) If veteran, name war: ---

3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife: ---

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name John T. O'Halloran
13. Birthplace Ireland

MOTHER
14. Maiden Name Abbie Doregan
15. Birthplace Ireland

16 (a) Informant ~~Miss Nellie O'Halloran~~
(b) Address 444 East 22nd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location City

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREENMOUNT AVE. & 22ND

19 (a) MAR 29 1948 (Date rec'd by registrar) Baltimore, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26/48 19..., at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-25 19 48, to 3-26 19 48, and that I last saw h-- alive on 3-26 19 48.

Immediate cause of death Coronary Thrombosis — Duration 1 da

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature P. F. Flynn M. D.
Address 1 E. Chase St Date signed 3-29-48

X

C61696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1228

Registered No. C61696

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 15-6 Maryland General

(c) Hospital or institution: Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3¼ hrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1908 Poplar Grove St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES H. ROBINSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Hazel Robinson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 2, 1890

8. AGE: Years	Months	Days	If less than one day
57	10	24	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Cashier

11. Industry or business Bldg & Loan.

FATHER 12. Name Charles E. Robinson

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Sadie E. Bunting

15. Birthplace Balto. Md.

16 (a) Informant Mrs. Hazel Robinson

(b) Address 1908 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-48 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk.

Location City

18 (a) Funeral director Wiedefeld & Son

(b) Address 1949 Greenmount Ave & 22nd

19 (a) MAR 29 1948 (Date rec'd by registrar) (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1948 at 9:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-26 1948 to 3-26-1948 and that I last saw him alive on 3-26 1948.

	Duration
Immediate cause of death: Respiratory failure	
Due to Aspiration of Stomach Contents	
Due to Intestinal Obstruction	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 3-26-48

Major findings of operation: Intestinal obstruction due to Kinking of Ileum

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Frank J. Brady M. D.

Address md. Gen. Hosp. Date signed 3-26-48

C61697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. C61697

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th Street
(c) Hospital or institution: Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-3-24
(e) Length of stay in Baltimore (yrs., mos., or days) 2-3-24

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Talbot Co.
(c) City or town CORDOVA
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Merrick

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8 - 1868

8. AGE: Years	Months	Days	If less than one day
79	5	20	hr. min.

9. Birthplace Talbot Co. - Md.
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name George W. Merrick
13. Birthplace Md.

MOTHER
14. Maiden Name Matilda Roe
15. Birthplace Md. Talbot Co.

16 (a) Informant Records, Home for Incurables
(b) Address 700 W. 40th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Bowie, Md.

18 (a) Funeral director Wm. J. Tucker & Son
(b) Address Bowie Md. Withdrawn for Williamsburg, Md.

19 (a) MAR 29 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1948, at 6:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 4th 1946, to March 28 1948, and that I last saw him alive on March 27th 1948

Immediate cause of death Uremia — Duration 2 weeks

Due to Arteriosclerotic Cardio-Vascular-Renal Disease — 15 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Conrad Wolf M. D.
Address 11 E. Chase St. Baltimore 2 Maryland
Date signed 3/28/48

VS 3

G61698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G61698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2 N. Glover St.,
(c) Hospital or institution: 6-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2 N. Glover St., (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Rosa

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Perry H. Rosa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1872

8. AGE: Years 76 | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name John Dougherty
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Don't know
15. Birthplace Don't know

16 (a) Informant Perry H. Rosa
(b) Address 2 N. Glover St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 30, 1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Rural

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Pleasant St. Huntington for Williams, Md.

19 (a) MAR 29 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26, 1948 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/16 1948 to 3/26 1948.
and that I last saw her alive on 3/26 1948.

Immediate cause of death: Chronic Myocarditis — Duration: ?

Due to Hypertensive Cardio-vascular-renal disease — Duration: 20 years

Due to

Other Conditions Cerebral Vascular Accident — Duration: 6 weeks
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melvin W. Borden M. D.
Address 2036 Fayette St. Date signed 3/27/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V3 153

661699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 111B

Registered No. 661699

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 106 N Streeper St
(c) Hospital or institution: 6-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 N Streeper St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elsa May Bremer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Benj F Bremner
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Aug 21. 1895

8. AGE: Years	Months	Days	If less than one day
52	7	7	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation
11. Industry or business at Home

FATHER
12. Name ~~Walter W Keeler~~ Lewell Johnson
13. Birthplace Balto

MOTHER
14. Maiden Name Roberta W Keeler
15. Birthplace Baltimore

16 (a) Informant Benjamin Bremner
(b) Address 106 N Streeper St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 31. (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem. City
Location

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St.

19 (a) MAR 29 1948 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1948, at 11:15 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature W. A. Helbrecht M.D.
Medical Examiner.
Date signed 3/29/48

X

661700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. 661700

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 134 S. Caroline St

(c) Hospital or institution: 3-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 134 S Caroline St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hattie Foulke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23-1904

8. AGE: Years	Months	Days	If less than one day
44 43	2	1	hr. min.

9. Birthplace Greenville N. C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business For Self

FATHER

12. Name Sob Harris

13. Birthplace Greenville N. C.

MOTHER

14. Maiden Name Fannie Bozlee

15 Birthplace Greenville N. C.

16 (a) Informant Bertha Newborn

(b) Address 9 N. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 31-1948 (month) (day) (year)

(c) Cemetery or crematory Mt Calvery Cem.

Location Brooklyn Md

18 (a) Funeral director Leroy O. Wilson

(b) Address 1030 Brantley Rd

19 (a) MAR 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24 1948, at 12 [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24 1948 to 3/24 1948, and that I last saw h.e.v. alive on 3/24 1948.

	Duration
Immediate cause of death Tuberculosis	
Due to	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. Pinta Grant

Address 154 Division 17 Date signed M. 3 D. 25/48

VS 130

X

G61701 118368

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131B

Registered No. G61701

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospital 3-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 E. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Oakey Crews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Ollie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1920

8. AGE: Years	Months	Days	If less than one day
27 28	4	18	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Will Crews (D)
13. Birthplace Va.

MOTHER
14. Maiden Name Minnie Wanack (D)
15. Birthplace Va.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 31-1948 (month) (day) (year)
(c) Cemetery or crematory Meadville Cem.
Location Halethorp e Va

18 (a) Funeral director Elroy O. Wilson
(b) Address 1010 Bloomfield Ave

19 (a) MAR 29 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1948, at 10-15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 23 1948, to March 27 1948. and that I last saw him alive on March 27 1948.

Immediate cause of death
Uremia
Due to Chronic Glomerulonephritis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. R. Scarborough M. D.
Address Balto City Hosp Date signed 3-28-48

Certificate for Williams, M.

661702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 661702

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 N. Spring St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMANUEL PAGE

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Maddlesex Co. Va.
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Ben Garrison Green
(b) Address 1512 May Court
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/98 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location Baltimore Md.
18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bloomsbury Ave
19 (a) MAR 29 1998 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/27/98 19 at 12:25 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 3/27/98

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G61703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH . 138

Registered No. G61703

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 5-1
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1219 E. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emmanuel Collins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1946

8. AGE: Years 2 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Raymond Collins
13. Birthplace N.C.

MOTHER
14. Maiden Name Ada King
15. Birthplace Broadneck Md

16 (a) Informant: Essie King
(b) Address 1237 St Matthews

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 30-1948 (month, day, year)
(c) Cemetery or crematory Mt Calvery Cem.
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Blanton ave

19 (a) MAR 29 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1948, at 8:00 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Miliary tbc.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature M.D.
Medical Examiner.
Date signed

VS 151

× T. L. Royer

G61704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

169

G61704 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 07
(c) Hospital or institution: University Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3602 Payne Street (If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME: William R. Barber

3 (b) If veteran, name war .....

3 (c) Social Security Account No. 218-03-7782

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mabel L. Barber

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) Oct 30, 1908

8. AGE: Years 39 | Months 4 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Brakeman

11. Industry or business B & O. R.R.

FATHER
12. Name Charles L. Barber, Sr.
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant: Mabel L. Barber
(b) Address 3602 Paine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1/48 (month) (day) (year)
(c) Cemetery or crematory St. Marys
Location Hampden

18 (a) Funeral director Timothy E. Donovan
(b) Address 3638 Roland Ave

19 MAR 29 1948 (Date received by Registrar) (b) Timothy for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1948, at 7 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage Ruptured Spleen - Ruptured Pancreas

Due to .....

Other Conditions Contusion Front. Left Thorax, Front. Epigastrium Pubis.
(Include information within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: By Physician

(a) Date of injury 3-27-48 at 6 P.M. 3614

(b) Where did injury occur? B & O R.R. -- Baggage Car

(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? yes

(d) Means of injury Caught between two moving freight cars

23. Signature Earl L. Lough M.D. (Medical Examiner)

Date signed 3-29-48

2424 St Paul St

661705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

Registered No. 661705

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 841 N 36th St.
(c) Hospital or institution: 12-06
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 841 N 36th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie E Rash.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 9 - 1892.

8. AGE: Years	Months	Days	If less than one day
55	4	17	hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Milliner

FATHER
12. Name William G Rash.
13. Birthplace Pa.

MOTHER
14. Maiden Name Angeline Mann
15. Birthplace Pa

16 (a) Informant Mrs Grace Rash Harris
(b) Address 841 N 36th St.

17 (a) Burial (b) Date thereof 3 - 30 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Grant H Seitz
(b) Address 814 N 36th St

19 (a) (b)
Date received by registrar Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1948, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947, to March 26 1948, and that I last saw h[illegible] alive on March 26 1948.

Immediate cause of death Coron. Cardiac
Coron. Cardiac
Acute Bright Disease
Due to Chronic Myo. Cardiac
Due to

Duration
1 day
1 Week
year

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert M Foster
Address 2424 St. Paul St Date signed (M. D.) 3-31-48

661706

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. 661706

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2927 GUILFORD AVE.
(c) Hospital or institution: NONE 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) NONE
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2927 GUILFORD AVE
(If NO give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH R. ONION.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) UNKNOWN

8. AGE: Years | Months | Days | If less than one day: hr. min.
apparently in Seventies

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Thomas Onion
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Elizabeth Rock
15. Birthplace Baltimore - Md.

16 (a) Informant Mrs. Arthur H. Lyons
(b) Address 626 Ryland Ave. Towson Md

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 3/30/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director E. Vernon Lonmon.
(b) Address 468 Park Heights.

MAR 29 1948

19 (a) (Date rec'd by registrar) Certificate for William

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 27 1948 19 , at 2.A.M

21. I certify that death occurred on the date above stated; that I attended deceased from MARCH 26, 48 to MARCH 27, 48
and that I last saw her alive on MARCH 27, 48.

Immediate cause of death	Duration
APOPLEXY. MARCH 26	1948.
Due to CHRONIC MYOCARDITIS.	1945
Due to ARTERIOR SCLEROSIS	1945.
Other Conditions NONE	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. F. Blandford
3013 ST PAUL STREET MARCH 27, 1948.
Address Date signed

VS 150

661707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 661707

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2830 E Baltimore St
(c) Hospital or institution: 6-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore St
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2830 E Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josiah J. Carroll

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Catherine M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 9. 1867

8. AGE: Years	Months	Days	If less than one day
81	1	19	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Special Clerk
11. Industry or business Retired Post Office

FATHER
12. Name Joseph Carroll
13. Birthplace England

MOTHER
14. Maiden Name Logan
15. Birthplace Ireland

16 (a) Informant Catherine M. Carroll
(b) Address 2830 E Baltimore St

17 (a) Burial (b) Date thereof March 31 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director John C Moran
(b) Address 3000 E Baltimore St

19 (a) MAR 29 1948 (b) Turnington Williams M.D.
(Date rec'd by reg'r) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1948 at 6.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-25 1947 to 3-28 1948 and that I last saw h[illegible] alive on 3-28 1948

Immediate cause of death	Duration
Myocardosis	
Due to Arteriosclerotic heart	
Due to disease arteriosclerosis	
Other Conditions Essential hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John J Gould M. D.
Address 14 N East ave Date signed 3-29-48.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

661708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1318

Registered No. 661708

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 27-5
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3031 PINEWOOD AVE. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MARY SHIRLEY ~~MARY~~ O'NEILL

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-24-5599

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/27/27

8. AGE: Years	Months	Days	If less than one day
20	7	1 —	hr. min.

9. Birthplace BALTIMORE. MD. (Town, county, and state)

10. Usual Occupation CLERK

11. Industry or business JOHN DEERE PLOW CO.

FATHER
12. Name James M. O'Neill
13. Birthplace Maryland

MOTHER
14. Maiden Name Regina Granlund
15. Birthplace Maryland

16 (a) Informant Mrs James M. O'Neill
(b) Address 3031 Pinewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John A. Moran
(b) Address 3060 E. Balt St. Funeral Home, Baltimore, Md.

19 (a) MAR 29 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/27 1948, at 2 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/13 1948 to 3/27 1948, and that I last saw her alive on 3/27 1948.

Immediate cause of death	Duration
UREMIA	
Due to CHRONIC GLOMERULAR	
Due to NEPHRITIS	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry J. Houska M. D.
Address St. Jos. Hosp. Date signed 3/27/48

VS 150

G61709

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G61709 ✓ Registered No. 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 19-4
(a) Baltimore City, Maryland
(b) Street address 1025 W. Fayette St
(c) Hospital or institution: Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17d.
(e) Length of stay in Baltimore (yrs., mos., or days) 39

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 Ramsay St - 23
(If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country ?

3 (a) FULL NAME Charles F. Moeller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mrs Nellie Moeller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-2-1896

8. AGE: Years	Months	Days	If less than one day
51	9	25	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Butcher
11. Industry or business Meat Store

FATHER
12. Name Joseph Moeller
13. Birthplace Germany

MOTHER
14. Maiden Name Carolyn —
15 Birthplace Germany

16 (a) Informant MRS CHARLES MOELLER
(b) Address 1621 RAMSAY ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MARCH 30'48 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location 600 FREDERICK RD

18 (a) Funeral director Harry N Wetzler
(b) Address 401 Edmondson Ave

MAR 29 1948 (Date rec'd by registrar) Twittington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-27 1948, at 5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-10 1948 to 3-27 1948, and that I last saw h[illegible] alive on 3-27 1948.

Immediate cause of death Hypostatic Pneumonia - Cerebro Vascular Accident — Duration

Due to

Due to Chronic Heart Failure

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George W. Fisher M. D.
Address Bon Secours Hosp Date signed 3-27

X

G61710 ✓ G61710

BC-C 79948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 102 W. 24th St.
(c) Hospital or institution: 12-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 W. 24th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: MARGARET A. HART

3 (b) If veteran, name war: -------

3 (c) Social Security Account No.: --------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife: ------

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1947.

8. AGE: Years	Months	Days	If less than one day
	9	29	hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Child

11. Industry or business

FATHER
12. Name: Charles Hart
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Margaret Thompson
15. Birthplace: England

16 (a) Informant: Charles Hart (Father)
(b) Address: 102 W. 24th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-48. (month) (day) (year)
(c) Cemetery or crematory: New Cathederal Cem.
Location: Old Frederick Rd.

18 (a) Funeral director: Charles S. Zeiler
(b) Address: 901 S. Conkling St.

19 (a) (Date received by registrar) (b) Registrar

MAR 29 1948

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1948, at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 19 1947 to 3/28 1948, and that I last saw her alive on 3/28 1948.

	Duration
Immediate cause of death: Mitral Regurgitation	4 mo
Due to:	
Due to: Myocardial Degeneration	3 day
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: David Mitchell MD

Address 1700 N Broadway Date signed 3/29/48 M/D.

X

G61711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G61711

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 424 Robert Street
(c) Hospital or institution: 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 74 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 424 Robert Street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Charles J. Weiss

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NO

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Eleanora Weiss
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) April 14, 1873

8. AGE: Years	Months	Days	If less than one day
74	11	13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Franz Karl Weiss
13. Birthplace Germany

MOTHER
14. Maiden Name Kundagsunda Seiler
15. Birthplace Germany

16 (a) Informant Mr. John C. Weiss
(b) Address 2930 Clifton Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 3/30/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) (Date received by local registrar) MAR 29 1948 (b) Thurlington Williamson, M.D.

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-27-1948 at 11A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1948 to 3-27 1948 and that I last saw h[illegible] alive on 3-25 1948

Immediate cause of death	Duration
Extensive cerebral Hemorrhage	5 hours
Due to arteriosclerosis	5 years
Due to Hypertention	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. Schwartz M. D.
Address Medical Arts Bldg Date signed 3-29-48

X

S-61712 ✓ S-61712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1820 Madison Ave
(c) Hospital or institution: 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mo's

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1820 Madison Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Roan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Jannie Roan
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Aug 5, 1885

8. AGE: Years	Months	Days	If less than one day
62	8	21	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Jannie Roan
(b) Address 1820 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/1948 (month) (day) (year)
(c) Cemetery or crematory Lanesville Md
Location Lanesville Md

18 (a) Funeral director Mrs. Edw. F. Holland
(b) Address 1631 Druid Hill Ave.

MAR 30 1948 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1948, at 2 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13 1947 to May 26 1948 and that I last saw him alive on May 23 1948

Immediate cause of death	Duration
Cardio Vascular Renal Disease	1 yr ?
Due to Broken Compensation	4 mo ?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr William Fray
Address 1928 Penna Ave Date signed 3/30/48 (M.D.)

VS 150

C61713

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. C61713

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2213 W. Hamburg St.
(c) Hospital or institution: 25-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2213 W. Hamburg St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Howard M. Washington

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Carrie Washington 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
78	1		hr. min.

9. Birthplace Harford Co. Md (Town, county, and state)
10. Usual Occupation Minister
11. Industry or business

FATHER
12. Name George Washington
13. Birthplace Harford Co. Md

MOTHER
14. Maiden Name Marie ?
15. Birthplace Md.

16 (a) Informant Mrs. Carrie Washington
(b) Address 2213 W. Hamburg St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md

18 (a) Funeral director Mrs. Frances H. Heywood
(b) Address 518 W. Biddle St

19 (a) MAR 30 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1948, at 1830 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed 3-29-48

VS 151

C61714

HL 19107

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93

Registered No. C61714

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospital 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 years
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 521 Gold St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John DeCoursey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife Blanche
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name Jacob DeCoursey
13. Birthplace Md.

MOTHER
14. Maiden Name Charlotte
15 Birthplace Md.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-31-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md

18 (a) Funeral director Wm. Francis A. Humphrey
(b) Address 578 W. Biddle St.

MAR 30 1948 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27, 1948, at 7-45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 30 1936 to March 27 1948 and that I last saw him alive on March 27 1948.

Immediate cause of death	Duration
Pulmonary Edema	
Due to Arteriosclerotic Heart Disease.	
Due to	
Other Conditions General arteriosclerosis.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed 3-29-48

VS 150

663715

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. 663715

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Mistakes corrected for binding

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4605 Eldorode Ave
(c) Hospital or institution: — 27-0-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4605 Eldorode Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wm J. Dohler
3 (b) If veteran, name war
3 (c) Social Security Account No. 218-01-9153
4. Sex M. 5. Color or race W. 6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Mary.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 27. 1866
8. AGE: Years 82 Months 3 Days If less than one day hr. min.
9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Conrad Dohler
13. Birthplace Bavaria Germany

MOTHER
14. Maiden Name Caroline Gingrass
15. Birthplace

16 (a) Informant Arthur C Dohler
(b) Address 6014 Burgess Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 30-48 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Old Annex
18 (a) Funeral director L. Hecmaxx & Son
(b) Address 6067 Harford Rd
MAR 30 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1948 at 4 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1948 to March 27 1948 and that I last saw h[illegible] alive on March 27 1948

	Duration
Immediate cause of death Coronary Thrombosis	acute
Due to Coronary Arteriosclerosis	4 yrs.
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Edward J Pringle M. D.
Address 7007 E Rogers Ave Date signed 3-28-48

VS 150

G61716

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G61716

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 17 E. Carter Mead (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John E. Monthley (Edward Monthley)

3 (b) If veteran, name war American

3 (c) Social Security Account No. 213-05-9978

4. Sex M | 5. Color or race W. | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife Mary Monthley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2nd 1873

8. AGE: Years 74 | Months 6 | Days 26 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired Welder

11. Industry or business Balto. Transit Co.

FATHER
12. Name Louis Monthley
13. Birthplace Md.

MOTHER
14. Maiden Name Julia Geis
15. Birthplace Md.

16 (a) Informant Mary Monthley
(b) Address 1410 Darley Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/1/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ U. S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 MAR 30 1948 (Date rec'd by registrar) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/28/48 19 , at 9:20 A. M.

~~20.~~ I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home or farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D. Medical Examiner
Date signed 3/29/48

G61717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

53

G61717 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 123 W 34th St
(c) Hospital or institution: 13-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mo.s
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 123 W 34th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. B Evans

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) ~~Single, married, widowed, or~~ divorced. Divorced

6 (b) Name of ~~husband or~~ wife Lucille

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jul. 3 1888

8. AGE: Years 60 | Months 1 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Asst Chief Accountant

11. ~~Industry or business~~ Intermediate Credit Bank

FATHER
12. Name Wm H. Evans
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Sarah A. Marsh
15. Birthplace Balto. Co. Md.

16 (a) Informant Wm M. Tefft
(b) Address 45 Shephard St. Chevy Chase, Md

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/30/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 E. Paul St.

19 (a) MAR 30 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1948 at 6 P M

21. I certify that I took charge of the remains described above, held an Inq & Insp thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said ~~Autopsy~~ Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cancer of face

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Kelsch M.D.
Medical Examiner.

Date signed 3/28/48

661718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 661718

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEMORY REGISTER FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1618 Harlem Ave.

(c) Hospital or institution: 16-3

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1618 Harlem Aver (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Jones,

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	Widower

6 (b) Name of husband or wife Margaret Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 1 1883

8. AGE: Years	Months	Days	If less than one day
65	1	7	hr. min.

9. Birthplace Prince George Co., Md. (Town, county, and state)

10. Usual Occupation City Worker.

11. Industry or business

FATHER 12. Name Michael Jones.

13. Birthplace Prince George Co. Md.

MOTHER 14. Maiden Name Annie Jackson.

15. Birthplace Prince George Co. Md.

16 (a) Informant Mrs. Mary Flemming

(b) Address 1618 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 30 1948 (month) (day) (year)

(c) Cemetery or crematory St. Augustine, Location Howard Co. Md.

18 (a) Funeral director Mrs Katie P. Williams

(b) Address 922 N. Schroeder St.

19 (a) 3 30 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26-1948 at 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1948 to 3/26 1948 and that I last saw him alive on 3/25 1948

Immediate cause of death Chronic Cardio Vascular Renal disease

Due to Uremia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
6 mos
2 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. D.

Address 600 Washington Ave Date signed 3/29/48

VS 150

C61719

337871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30a

Registered No. C61719

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-0

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County .....

(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)

(d) Street No. 1101 Slater Rd. Cherry Hill (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) **FULL NAME** Russell Parks.

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	S.

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) 3-9-1912

8. AGE: Years	Months	Days	If less than one day
36	-	18	..... hr. ..... min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER

12. Name George Parks

13. Birthplace Va.

MOTHER

14. Maiden Name Margaret Burts

15. Birthplace N.Y.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-31-48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cy

Location Balto Co. Md

18 (a) Funeral director Isaiah L. Brown Son

(b) Address 108 W Montgomery St

MAR 30 1948 (Date rec'd by registrar) Huntingtown Williams Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March-27-1948 at 5-45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-24-1948 to 3-27-1948. and that I last saw him alive on 3-27-1948.

Immediate cause of death Ruptured aortic aneurysm — Duration Four

Due to Syphilitic aortic aneurysm

Due to .....

Other Conditions Takes Dorsulis

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: .....

of autopsy: same as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence None at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....

(e) Means of injury .....

23. Signature Thomas E. Van Metre M.D.

Address Johns Hopkins Hosp. Date signed 3/27/48

VS 150

X

G61720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G617203698

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1357 N. Carey St.
(c) Hospital or institution: 13-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2258 Morris St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carroll Rice

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex M | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced. widowed

(b) Name of husband or wife Mrs Ola Rice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1895

8. AGE: Years 52 | Months 7 | Days | If less than one day ... hr. ... min.

9. Birthplace Lancaster Co. Va
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Jobber

FATHER
12. Name Robert Rice
13. Birthplace Va.

MOTHER
14. Maiden Name Maria Monroe
15. Birthplace Va

16 (a) Informant Alberta Rock
(b) Address 1357 Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 30 /48 (month) (day) (year)

(c) Cemetery or crematory Greenmount Park
Location Baltimore

18 (a) Funeral director Wm Brookes
(b) Address 1463 N. Carey St

19 MAR 30 1948 Filed [illegible] Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-27- 1948, at 5:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-2- 1947, to 3-27- 1948, and that I last saw him alive on 3-27- 1948.

Immediate cause of death nephritis — Duration unknown

Due to — Duration

Due to — Duration

Other Conditions Myocarditis & Hypertension arteriosclerosis — Duration unknown
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1 Egn. Stricker St Date signed 3-27-48

VS 150

061721

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 1245 061721

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen'l Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 dys
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town ~~Baltimore~~ Anneslie
(If outside city or town limits, write RURAL and give town)
(d) Street No. 624 Overbrook Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry G. Hawkins.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Stella B. Hawkins ~~Bertha E.~~

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1892

8. AGE: Years 55 | Months 6 | Days 0 | If less than one day: hr. min.

9. Birthplace Roanoke, Va.
(Town, county, and state)

10. Usual Occupation Executive Assistant

11. Industry or business Bureau of Temporary Controls U.S.Government

FATHER
12. Name Benjamin Franklin Hawkins
13. Birthplace Bentonville, Va.

MOTHER
14. Maiden Name Jennie E. Printz
15. Birthplace Luray, Va.

16 (a) Informant Mrs. Harry G. Hawkins
(b) Address 624 Overbrook Rd., Anneslie

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 31, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miles Lawrence
(b) Address 4510 Liberty Heights Ave.

MAR 30 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1948, at 8:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/9 1948 to 3/29 1948.
and that I last saw him alive on 3/29 1948.

Immediate cause of death: Cerebral Thrombosis — Duration: over

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3/15/48.

Major findings of operation:

Inflammatory, Mass - Cancer

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene G. Cameron M. D.

Address Maryland Gen'l Hosp. Date signed 3/29

VS 150

831

C61722

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

Registered No. C61722

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2027 Eagle St
(c) Hospital or institution: 20-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2027 Eagle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Adler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Abraham —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
79			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Samuel
13. Birthplace Russia

MOTHER
14. Maiden Name Bernice
15. Birthplace Russia

16 (a) Informant M. Milton Adler
(b) Address 2027 Eagle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt. Carmel
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 200 Eutaw Place

19 (a) MAR 30 1948 (Date received by registrar) (b) Huntingtown Williams MD (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-29- 1948 at 4 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24 1948 to 3/29 1948 and that I last saw h-er alive on 3/29 1948

Immediate cause of death: arteriosclerotic cerebral vascular disease — Duration 2 days
Due to:
Due to:
Other Conditions: Cerebral hemorrhage — 4 days
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury?

23. Signature Benjamin Muller M. D.
Address 2030 Wilkens Date signed 3/30/48

V S 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a ✓ Registered No. 661723

661723

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ARROW RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1540 Aisquith St.
(c) Hospital or institution: 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1540 Aisquith St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph (Zahradka) Gardner

3 (b) If veteran, name war

3 (c) Social Security Account No. 2/603-4802

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Alice E. Zahradka
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5, 1903

8. AGE: Years	Months	Days	If less than one day
44	5	22	hr. min.

9. Birthplace Czecho Slovakia (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Joseph Zahradka
13. Birthplace Czecho Slovakia

MOTHER
14. Maiden Name Bessie Steckel
15. Birthplace Czecho Slovakia

16 (a) Informant Mrs. Alice E. Zahradka
(b) Address 1540 Aisquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 / 30 / 48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location 1930 Frederick Road

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 4914 Belair Road

19 (a) Date received MAR 30 1948 (Registrar) Thurlington Williams M.D. (Registrar)

V S 190 . . . 6

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1948, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1948 to Mar. 27 1948 and that I last saw h... alive on Mar. 22, 1948

Immediate cause of death: Coronary Thrombosis — Angina Pectoris — Duration 1/2 hr. — 1 week

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Spencer
Address 1402 E. Lanvale Date signed 3-29-48 M.D.

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66724

117a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Lingner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22- 1897

8. AGE: Years 51 | Months 2 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name Francis Lingner
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna Rolfe
15. Birthplace Baltimore, Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4 / 1 / 48 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST - 30

19 MAR 30 1948 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29- 1948, at 7Pm M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-26- 1948 to 3-29- 1948, and that I last saw him alive on 3-29- 1948.

Immediate cause of death Generalized peritonitis — Duration 4 d

Due to Perforated gastric ulcer — 4 d

Due to — 3 d.

Other Conditions Bronchopneumonia

(Include pregnancy within 3 months of death)

Date of operation 3/26/48

Major findings of operation: perforated ulcer

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gordon Craft, M. D.
Address Balt City, Hosp. Date signed 3/30/48

VS 150

C61725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 510

C61725 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 824 N. BENTALOU ST
(c) Hospital or institution: 16-5
PLACE OF DEATH
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 YRS
(e) Length of stay in Baltimore (yrs., mos., or days) 45 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 824 N. BENTALOU ST (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER G. HUGHES

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife: MARGARET ANN (BRADLEY)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 6, 1881

8. AGE: Years	Months	Days	If less than one day
66	4	22	hr. min.

9. Birthplace HANCOCK, MD. (Town, county, and state)
10. Usual Occupation PRINTER
11. Industry or business U. S. GOVERNMENT

FATHER
12. Name THOMAS HUGHES
13. Birthplace ENGLAND

MOTHER
14. Maiden Name MARY V. BOWHAY
15. Birthplace ENGLAND

16 (a) Informant MRS. MARGARET A. HUGHES
(b) Address 824 N. BENTALOU ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/31/48 (month) (day) (year)
(c) Cemetery or crematory LORRAINE
Location BALTO Co. MD.

18 (a) Funeral director WM J. TICKNER & SONS
(b) Address BALTO. MD.

19 MAR 30 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION 45

20. DATE OF DEATH 3/28 1948, at 7 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1948 to March 28 1948, and that I last saw h[illegible] alive on March 27 19 48.

Immediate cause of death: Carcinoma of prostate c
secondaries to bone

Duration: 8 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert J. Rhodes M.D.
Address 2302 Eutaw Pl. Date signed 3/28/48

VS 150

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G61726

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. G61726

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Cecil Apts., Eutaw Place
(c) Hospital or institution: none 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days): 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: none
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: Cecil Apts., Eutaw Place
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Annah Coleman

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 1869

8. AGE: Years	Months	Days	If less than one day
79	1		hr. min.

9. Birthplace: Fon du Lac, Wis.
(Town, county, and state)
10. Usual Occupation: none
11. Industry or business

FATHER
12. Name: James Coleman
13. Birthplace: Wis.

MOTHER
14. Maiden Name: Annah
15. Birthplace: Wis.

16 (a) Informant: Theresa M. Grob
(b) Address: 506 Harwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3/31/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~: Fort Lincoln
Location:

18 (a) Funeral director: John O. Mitchell & Sons Inc
(b) Address: 1900 Eutaw Place

19 (a) MAR 30 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 30, 1943 to 3-29, 1948. and that I last saw h-as alive on 3-29-1948.

Immediate cause of death	Duration
Coronary occlusion	acute
Due to Arterio-sclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Nathan Bikerman M. D.
Address: 1041 St. Paul St. Date signed: 3-30-48

VS 150

Dr. Herman X

661727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56E

661727 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3-2
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 E. Oraton
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis E Snyder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 3-9-41

8. AGE: Years 7 | Months 0 | Days 22 | If less than one day — hr. — min.

9. Birthplace Md, Cumberland.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name P

13. Birthplace P.

MOTHER 14. Maiden Name Essie Studt

15. Birthplace W. Va.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial. (b) Date thereof April 4 1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Frankfort Cemetery
Location Fort Ashby, W. Va.

18 (a) Funeral director Walter Burpee Bradley

(b) Address 1922 W. North Ave

MAR 20 1948 (Date rec'd by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-29-1948, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-22 1948 to 3-29 1948 and that I last saw him alive on 3-29 1948.

Immediate cause of death: Mediastinal tumor — Duration 7 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 29 March 48

Major findings of operation: Mediastinal tumor

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Huggins M.D.

Address Johns Hopkins Hospital (Date signed) 30 Mar 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. CG1728

~~CG1728~~ 798

107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospital 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 years
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 449 Oxford Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Haskins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1907

8. AGE: Years	Months	Days	If less than one day
40	9	18	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Haskins
13. Birthplace Va.

MOTHER
14. Maiden Name Elizabeth Coates
15. Birthplace Md.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 4/1/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Arbutus, Maryland.

18 (a) Funeral director Charles R. Shaw
(b) Address 802 Madison Ave.

MAR 30 1948
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1948, at 7- A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 1943, to March 29 1948, and that I last saw h im alive on March 29 1948.

Immediate cause of death	Duration
Bronchopneumonia	5 days
Due to	
Due to	
Other Conditions Complicated Syphilis	40 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julius Stoll, Jr. M. D.
Address Stoll: City Hosp. Date signed 3/29/48

VS 150

661729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

661729 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 16-2
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 W. Lanvale (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bessie Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Bennie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/19/1900

8. AGE: Years	Months	Days	If less than one day
48	1	10	hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation H. Wife

11. Industry or business

FATHER
12. Name Mose Smith
13. Birthplace N.C

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Bennie Smith
(b) Address 301 Presstman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 1, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Hes. H. Nelson
(b) Address 1303 Presstman St

19 MAR 30 1948 Registered by (Date filed) (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1948, at 10 45 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L Ryder M.D. Medical Examiner
Date signed 3-29-48

VS 151

X

G61730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G61730

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5604 Belle Vista Avenue
(c) Hospital or institution: — — None — 27-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5604 Belle Vista Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country — — —

3 (a) FULL NAME THOMAS ALEXANDER HOOE

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ida M. Hooe
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) 3-11-1868

8. AGE: Years	Months	Days	If less than one day
80	0	17	..... hr. ..... min.

9. Birthplace Charlestown, W. Va. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John H. Hooe
13. Birthplace West Virginia

MOTHER
14. Maiden Name Adizra Manuel
15 Birthplace West Virginia

16 (a) Informant Emma M. Downing
(b) Address 1220 N. Bradford Ave. (13)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-31-1948 (month) (day) (year)
(c) Cemetery or crematory Edge Hill Cemetery
Location Charles Town, West Virginia

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 South Wolfe Street (31)

19 MAR 30 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 1948, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1948 to March 28 1948, and that I last saw him alive on 3-28 1948.

Immediate cause of death	Duration
Chronic Nephritis	3 mos.
Due to Hypertension + Cerebral Hem.	?
Due to	—
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Michael Montalbano M.D.
Address 5707 Belair Rd Date signed 3-29-48

VS 150

661731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

477

Registered No. 661731

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1-2
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3111 Fleet St. #24 (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Clarence J. Irwin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Theresa Irwin

6 (b) Name of husband or wife Banashak

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/6/94

8. AGE: Years	Months	Days	If less than one day
53	6	24	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Theresa Irwin-wife
(b) Address 3111 Fleet St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave

18 (a) Funeral director Selby-Zeiler Co.
(b) Address 403 S. Wolfe St.

19 MAR 30 1948 Hunting for Williams M.D.
(Date rec'd by Registrar)

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1948, at 1:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 27 1948 to March 30 1948, and that I last saw him alive on March 29 1948.

Immediate cause of death	Duration
Cardio-respiratory failure	30 minutes
Due to Carcinoma of left lung with multiple metastasis	8 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alfred H. Dann M. D.
Address Maryland Gen'l Hosp. Date signed 3/30/48

61732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 61732

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Athol ave.
(c) Hospital or institution: Gen'l Germen Aged Home 284
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. Athol ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Albert Henry Mehn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12, 1859

8. AGE: Years	Months	Days	If less than one day
88	6	16	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Conrad Mehn
13. Birthplace Germany

MOTHER
14. Maiden Name Loretta Posch
15. Birthplace Germany

16 (a) Informant Mrs. Waltz
(b) Address 22 S. Athol Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Harry A. Wiltze
(b) Address 4101 E Monument Ave

19 (a) MAR 30 1948 (Date rec'd by Registrar) (b) [illegible] Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1948 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch. 20/48 to Mch. 28/48, and that I last saw him alive on Mch. 19/48.

Immediate cause of death
Lobar Pneumonia — Duration: 8 days
Due to
Due to
Other Conditions
Arterio-Sclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature R. Lucas Weeks Jr. M. D.
Address 933 Hanover St. Date signed Mch. 29/48.

VS-150

061733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163H

Registered No. 061733

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13-3
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dne
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2545 Woodbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (James LANDON) Samuel J. Lankford

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1948, at 4 P.M.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Married

6 (b) Name of husband or wife Maude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1897

8. AGE: Years	Months	Days	If less than one day
50	8	20	hr. min.

9. Birthplace Salisbury Md
(Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Clara Lankford
15. Birthplace Md

16 (a) Informant Mrs. Maude Lankford
(b) Address 2545 Woodbrook Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Wm. Katie R. Williams
(b) Address 322 N. Arlington Ave

19 (a) 3-30-1948 (Date received by registrar) (b) Huntington Williams, M.D.

21. I certify that I took charge of the remains described above, held an Inspection and Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to Self-inflicted Gas
Other Conditions Unknown
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-27-48 at about 7:30 A.M.
(b) Where did injury occur? Apt. in front Bath Rm. Church Street and Arbutus Md
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Inhaled gas from gas stove range

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 3/27/48

VS 151

C61734

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 218

Registered No. C61734

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~University Hospital~~
(c) Hospital or institution: 18-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1036 W. Fayette St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Kier, Daniel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	married

6 (b) Name of husband or wife Lillian Kier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1904.

8. AGE: Years	Months	Days	If less than one day
44	1	26	hr. min.

9. Birthplace Lexington, Virginia (Town, county, and state)
10. Usual Occupation Bethlehem Steel Co.
11. Industry or business

FATHER
12. Name Charles Kiery.
13. Birthplace Lexington, Virginia

MOTHER
14. Maiden Name Sophie Kiely
15. Birthplace Lexington Virginia

16 (a) Informant Mrs. Lillian Kier
(b) Address 1036 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 31, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 922 W. Baltimore

19 MAR 30 1948 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-27 1948, at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-17 1948, to 3-27 1948, and that I last saw h[illegible]live on 3-27 1948.

Immediate cause of death Cardio respiratory failure — Duration

Due to Tuberculous Pericarditis & pericardial effusion

Due to

Other Conditions Thoracic Duct Obstruction + Lymphedema
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. L. Jamison, M.D.
Address Univ. Hosp. Balto. Date signed 3/27/48

VS 150

C61735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C61735

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 2137 Eagle St
(c) Hospital or institution: 20-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 2137 Eagle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME Bluma Bertha Winer

3.15

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Myron Moses

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 78 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation:

11. Industry or business: House Wife

FATHER
12. Name: Benjamin Dunne
13. Birthplace: Russia

MOTHER
14. Maiden Name: Mollie Merowitz
15. Birthplace: Russia

16 (a) Informant: Robert Winer
(b) Address: 2125 Eagle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 31, 1948 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Washington Road
Location: Washington Blvd

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 MAR 30 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1948 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/9 1948 to 3/30 1948, and that I last saw h[illegible] alive on 3/30 1948

Immediate cause of death	Duration
arterio-sclerotic cardio vascular disease	2 yrs
Due to	
Due to	
Other Conditions Bronchopneumonia	1 wk

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Benjamin Miller M. D.
Address: 20 E. Wilkens Ave Date signed: 3/30/48

X

Dr. Herrmann

C61736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

Registered No. C61736

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5409 Grindon Avenue
(c) Hospital or institution: 27.6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5409 Grindon Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lena Wildberger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Frederick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1864

8. AGE: Years	Months	Days	If less than one day
83	8	4	hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Frederick Arnold
13. Birthplace Germany

MOTHER
14. Maiden Name Marguerite Riedinger
15. Birthplace ?

16 (a) Informant Mr. Malster Wildberger
(b) Address 5409 Grindon Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, #14

19 (a) MAR 30 1948 (Date rec'd by registrar) (b) Interring Witness, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1948 6 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1/47 19 to 3/29/48 19, and that I last saw h[illegible] alive on 3/29/48 19.

Immediate cause of death	Duration
a Myocarditis Chronic	2 mos
Due to Arteriosclerosis	10 yrs
Due to Hypertension	10 yrs
Other Conditions none	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. W. Herrmann M. D.
Address 1710 E 33rd St Date signed 3/30/48

C61737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. C61737

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Central Ave.
(c) Hospital or institution: 5-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 27 N. Central Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harvey Morris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col.	Married

6 (b) Name of husband or wife Dora Sedonia Morris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1894

8. AGE: Years	Months	Days	If less than one day
53	11	12	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Dora Sedonia E. Morris
(b) Address 27 N. Central

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 31 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location A. A. County Md.

18 (a) Funeral director Mc Rott & Edelen & Dugley
(b) Address 1129 N. Caroline St.

19 MAR 30 1948 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1948, at 4:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/21 1947 to 3/27 1948 and that I last saw him alive on 3-24 1948.

Immediate cause of death	Duration
hypertensive cardio-renal disease (uremia)	sev. yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at P.M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rayner Browne M.D.
Address 1500 E. Madison St Date signed 3/29

VS 193

Rayner Browne X

661738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

661738 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1243 Orleans St
(c) Hospital or institution: 5-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1243 Orleans (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Bazel
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	Col.	Married

6 (b) Name of husband or wife Gertrude Bazel
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 7, 1887

8. AGE: Years	Months	Days	If less than one day
60	8	19	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Eleck Bazel
13. Birthplace Md.

MOTHER
14. Maiden Name Irene
15. Birthplace Md.

16 (a) Informant Gertrude Bazel
(b) Address 1243 Orleans St.

17 (a) Burial (b) Date thereof 3/30/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Anne Arundel County Md.

18 (a) Funeral director Mrs. Robt. A. Elliott
(b) Address 1129 N. Caroline St

19 (a) MAR 30 1948 (b)
(Date rec'd by registrar) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26- 1948, at 6.25 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-3- 1948, to 3-26 1948, and that I last saw him alive on 3-24- 1948.

Immediate cause of death	Duration
Cardio-renal disease	Unknown
Due to	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Robt. A. Campbell M. D.
Address 611 N. Caroline St Date signed 3-27-48

061739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

Registered No. 061739

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 5-2
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 E. Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ada (Bailey) Dailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife Accie Dailey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1892

8. AGE: Years	Months	Days	If less than one day
56	8	17	hr. min.

9. Birthplace Blackstone Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Hudson
13. Birthplace Va.

MOTHER
14. Maiden Name Emma Bland
15. Birthplace Va.

16 (a) Informant Marie James
(b) Address 1101 E. Monument St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof March 30 1948 (month) (day) (year)
(c) Cemetery or crematory
Location Blackstone Va

18 (a) Funeral director Mrs Pott. A. Elliott & Daughter
(b) Address 1297 N. Caroline St

19 (a) MAR 30 1948 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1948 at 4 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home or farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Medical Examiner M.D.
Date signed 3-27-48

G61740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 114E

Registered No. G61740

G61750 269186

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 8-07

(d) Length of stay in hospital or inst. (yrs., mos., or days).....

(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County.....

(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)

(d) Street No. 1104 N. Washington, St. (If rural give location)

(e) Citizen of foreign country?..... (Yes or No)

If yes, name country.....

3 (a) FULL NAME David Little.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1-27-20

8. AGE: Years	Months	Days	If less than one day
28	2	1	..... hr. ..... min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Marshall Little

13. Birthplace N.C.

MOTHER 14. Maiden Name Loma Wentz

15. Birthplace N.C.

16 (a) Informant.....

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof March 31 1948 (month) (day) (year)

(c) Cemetery or crematory.....

Location Charlotte N.C.

18 (a) Funeral director Mrs Lott A. Elliott & Dgt

(b) Address 112 N. Carolina St

19 (a) MAR 30 1948 (Date rec'd by registrar) (b) [illegible] Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28- 1948 at 1 46 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-26- 1948 to 3-28- 1948 and that I last saw him alive on 3-28- 1948.

Immediate cause of death Filariasis of Lymph, communicum Cor Pulmonale — Duration ? 1 year

Due to.....

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:.....

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.....

(b) Date of occurrence..... at ..... M

(c) Where did injury occur? None (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)

(e) Means of injury.....

23. Signature T. Thomas B. VanMeter M.D.

Address Johns Hopkins Hosp. Date signed 3-29-48

X

061741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 061741

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1809 Braddish Avenue
(c) Hospital or institution: 15-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 Braddish Avenue (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME CHAUDE R. ROBERTS

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/1/1874

8. AGE: Years	Months	Days	If less than one day
73	7	28	hr. min.

9. Birthplace Balto. MD. (Town, county, and state)
10. Usual Occupation RETIRED — SALESMAN
11. Industry or business —

FATHER
12. Name WM F. ROBERTS
13. Birthplace BALTO., MD.

MOTHER
14. Maiden Name GEORGIA GLENN
15. Birthplace BALTO., MD.

16 (a) Informant MR. WM. C. ROBERTS
(b) Address 1809 BRADDISH AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/31/48 (month) (day) (year)
(c) Cemetery or ~~cremetery~~ BALTIMORE
Location BALTO., MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTO., MD.

19 (a) MAR 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29/48 19..., at 10:10 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..., ... M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? ... While at work? ...
(d) Means of injury —

23. Signature John R. Davis M.D. Medical Examiner.
Date signed 3/29/48

X

661742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 661742

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1827 Fleet Street
(c) Hospital or institution: 2-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1827 Fleet Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME KONSTANTY (GUSTAVE) PIECZYNSKI

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-3176

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) October 19, 1878

8. AGE: Years	Months	Days	If less than one day
69	5	10	..... hr. ..... min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

MOTHER / FATHER

12. Name ------- Pieczynski

13. Birthplace Germany

14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Mrs. Mary Pieczynski

(b) Address 1827 Fleet Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1, 1948 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Mt. Carmel Road

18 (a) Funeral director M. F. Sadowski & Sons

(b) Address 1808 Eastern Avenue

19 (a) MAR 30 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 29 1948, at 3:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 12 1946, to Mar 29 1948, and that I last saw him alive on Mar 29 1948.

Immediate cause of death	Duration
Cerebral hemorrhage	4 days
Due to Arteriosclerotic cardio vascular disease &	
~~Due to~~ hypertension	years
~~Other Conditions~~	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Sigmund R. Nowak M.D.

Address 408 S. Odtt Ph. Cne Date signed 3/30/48

VS 150

X

G61743

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

47c

Registered No. G61743

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1350 Crofton Rd.
(c) Hospital or institution: 27-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1350 Crofton Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Olive A. Knight

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10, 1884

8. AGE: Years	Months	Days	If less than one day
63	7 6	18	hr. min.

9. Birthplace Indiana
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Cyrus Knight.
13. Birthplace Del.

MOTHER
14. Maiden Name Martha Forbes
15. Birthplace Ken.

16 (a) Informant Miss Merran E. Reader
(b) Address 1350 Crofton Rd

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 3.31.48 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Witzke
(b) Address 4616 Edmondson Ave

19 MAR 30 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 30 December 1947 to 28 March 1948 and that I last saw her alive on 28 March 1948

Immediate cause of death Bronchogenic Carcinoma Left Upper Lobe Lung with metastases

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Kennedy Waller M. D.
Address 512 Cathedral St Date signed 30 March 1948

Registrar for Williams

VS 150

X

61744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G61744

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Mt. Washington
(b) Street address — 2207 South ave.
(c) Hospital or institution: — 27-15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) — Life

2. USUAL RESIDENCE OF DECEASED:
(a) State — Md. (b) County
(c) City or town — Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. — 2207 South ave.
(If rural give location)
(e) Citizen of foreign country? — NO (Yes or No)
If yes, name country

3 (a) FULL NAME — LOUIS A. MASTERMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	married

6 (b) Name of husband or wife — Agnes Masterman
6 (c) If alive, give age — 70 years

7. Birth date of deceased (mo., day, yr.) — Apr. 12, 1863

8. AGE: Years	Months	Days	If less than one day
84	11	16	..... hr. ..... min.

9. Birthplace — Baltimore, Maryland (Town, county, and state)
10. Usual Occupation — Retired Jeweler
11. Industry or business

FATHER
12. Name — Charles Masterman
13. Birthplace — Germany

MOTHER
14. Maiden Name — Anna Gavengort
15. Birthplace — Germany

16 (a) Informant — Mrs. Joseph A. Renehan
(b) Address — 2207 South avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof — 3/31/48 (month) (day) (year)
(c) Cemetery or crematory — Cathedral
Location

18 (a) Funeral director — Chas. J. Evans & Son, Inc.
(b) Address — 118 W. Mt. Royal Ave.

19 (a) MAR 30 1948 (Date rec'd by registrar) — Registered — Washington Avenue, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH — March 28 1948, at ..... M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 48 to March 28 19 48 and that I last saw h in alive on 3/28/48 19 48.

Immediate cause of death — Myocardial infarction — Duration 3 weeks

Due to — arteriosclerosis — Duration

Cardio-vascular disease 3 yrs

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature — Paul E. Cornelius M. D.
Address — 2217 South rd Date signed 3/29/48

VS 150

X

66 1745

AB-117920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registration No. 66 1745

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 3-1

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days

(e) Length of stay in Baltimore (yrs., mos., or days) 14yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 29 S.Caroline St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Cherry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 9- 1894

8. AGE: Years	Months	Days	If less than one day
54	11	28	hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Henry Cherry

13. Birthplace S.C.

MOTHER

14. Maiden Name Margaret Ann Cherry

15 Birthplace N.C.

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Local Johns Hopkins Medical Schoo MAR 22 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) MAR 30 1948 Hunter Lee Williams Registrar

(Date rec'd by registrar)

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1948, at 9.20AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4- 1948, to 3-7- 1948, and that I last saw him alive on 3-7- 1948

Immediate cause of death	Duration
Shock	2 days
Due to Coronary Occlusion probable	2days
Due to	
Other Conditions Asthma, bronchial spa	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. Robinson J

Address Bal City Hosp Date signed 3/30/48 M.D.

G61746 Birth Certificate 48-06008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G61746

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette
(c) Hospital or institution: Franklin Square
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2-9 Glenwood Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Boy Hahn Twin #1

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/16/48

8. AGE: Years	Months	Days	If less than one day
			hr. 10 min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business —

MOTHER / FATHER
12. Name Henry L. Hahn
13. Birthplace
14. Maiden Name Edgbach
15. Birthplace

16 (a) Informant Mother's Chart
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo MAR 22 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 30 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16 1948, at 3:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/16 1948, to 3/16 1948, and that I last saw him alive on 3/16 1948

Immediate cause of death	Duration
Atelectasis	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. H. Coffee M. D.
Address Franklin Square Date signed 3/30/48

661747 Birth Certificate 48-06609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 661747

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calhoun & Fayette

(c) Hospital or institution: Franklin Square

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Baltimore Essex (If outside city or town limits, write RURAL and give town)

(d) Street No. 2-E Glenwood Rd (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country —

3 (a) **FULL NAME** Baby Girl Hahn twin #2

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/16/48

8. AGE: Years | Months | Days | If less than one day: 10 hr. 30 min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Harry L. Hahn

13. Birthplace

MOTHER 14. Maiden Name Elizabeth

15. Birthplace Mother's Chart

16 (a) Informant Mother's Chart

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Local Johns Hopkins Medical Schoo MAR 22 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 MAR 30 1948 (Date rec'd by registrar) Hunting for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17 1948, at 2:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/16 1948 to 3/17 1948, and that I last saw her alive on 3/17 1948

Immediate cause of death	Duration
Asthelectasis	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Malfa M. D.

Address Franklin Square Date signed 3/30/48

VS 150

661748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. 663748

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 303
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2414 Madison Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country None

3 (a) FULL NAME Carrie Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/3/1884

8. AGE: Years 47 | Months 7 | Days 14 | If less than one day hr. min.

9. Birthplace Ashland Co. Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name James Burley
13. Birthplace Va

MOTHER 14. Maiden Name Mildred Temple
15. Birthplace Va

16 (a) Informant William S. Jackson
(b) Address 2414 Madison ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-30-48 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Mt Auburn

18 (a) Funeral director William A Jackson
(b) Address 916 Penna Ave

19 (a) MAR 30 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17 1948 at 4:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/8 1948 to 3/17 1948, and that I last saw h[illegible] alive on 3/16 1948

Immediate cause of death: Hypertensive Cardio-Renal Disease

Duration: 7 yrs.

Due to

Due to Uremia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature of M. D.

Address 2243 Madison Ave Date signed 3/18/48

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

661749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 661749

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Bedford (If outside city or town limits, write RURAL and give town)
(d) Street No. 301 W. Pitt St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard W. Beam

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 7-31-38

8. AGE: Years 9 | Months 7 | Days 29 | If less than one day hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Richard Beam

13. Birthplace Pa.

MOTHER 14. Maiden Name Laverne Mundwiler

15. Birthplace Pa

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3 (month) 30 (day) 48 (year)

(c) Cemetery or crematory Bedford

Location Bedford Pa

18 (a) Funeral director Wm. J. Fisher & Son

(b) Address Pitt & Penn Ave.

19 (a) MAR 30 1948 (Date rec'd by registrar) (b) Huntingtown Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 30 1948, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-23- 1948 to 3-30- 1948 and that I last saw h[illegible]live on 3-30- 1948.

Immediate cause of death	Duration
Pulmonary Edema	72 hrs
Due to Cardiac Failure	72 hrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 25-Mar 48

Major findings of operation: Pulmonic Stenosis

of autopsy: Transposition Great vessels

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. R. Canted MD M. D.
The Johns Hopkins Hospital
Address Date signed 30-Mar-48

VS 159

61750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G61750

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 721 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James C. Fury

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-20-1975

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/16/[illegible]

8. AGE: Years 70 | Months 5 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Elmer Linder
(b) Address 414 S. Cedar Lane Upper Darby Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1 1948 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Harry J. Mumaccok
(b) Address 420 Rodenwood Lane Huntingtown Williamsport Md

19 (a) MAR 30 1948 (Date received by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25/48 19 7:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] Davis M.D. (Medical Examiner)
Date signed 3/25/48

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 61751

61751

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 404-N. Bruce St.
(c) Hospital or institution: 20-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 404-N. Bruce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carrie E. Mitchem.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Thomas A. Mitchem
6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) April, 29-1878.

8. AGE: Years	Months	Days	If less than one day
69	11	0	hr. min.

9. Birthplace Mathews Co. Virginia. (town, county, and state)
10. Usual Occupation Retired House Wife.
11. Industry or business

FATHER
12. Name Edward Filmore Forest.
13. Birthplace Virginia.

MOTHER
14. Maiden Name — Wheatley.
15. Birthplace Unknown.

16 (a) Informant Charles E. Hurst.
(b) Address 404-N. Bruce St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/31/48 (month) (day) (year)
(c) Cemetery or crematory Island Cemetery
Location Mathews Co. Virginia.

18 (a) Funeral director Charles J. Dehuff
(b) Address 3512-Fredrick Ave.

19 MAR 30 1948 (Date rec'd by registrar) (Signature for Williams M...)

MEDICAL CERTIFICATION

20. DATE OF DEATH March, 29 - 1948 at 4.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1948 to Mar. 29 1948 and that I last saw h— alive on Mar. 26 1948.

Immediate cause of death: Pulmonary Oedema
Due to: Chronic Cardio-pulmonary
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration
1 hr.
11 Mos
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James N. Talyntyre M. D.
Address 721 Madison Ave Date signed 3/30/48

V S 150

061752 1875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 061752

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Cold Spring Lane
(c) Hospital or institution:
COLD SPRING NURSING HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Long Green
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Maul

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 20 1875

8. AGE: Years	Months	Days	If less than one day
73	1	6	hr. min.

9. Birthplace Balto. Co Md (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name John F. Maul
13. Birthplace Balto Co Md

MOTHER
14. Maiden Name Rebecca Green
15. Birthplace Balto. Co. Md

16 (a) Informant Maurice Yoder
(b) Address Long Green Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 31/48 (month) (day) (year)
(c) Cemetery or crematory Sweet Air Lutheran Cem
Location Sweet Air Balto Co Md

18 (a) Funeral director Henry W. Jenkins & Sons
(b) Address Dr. & Gallert Orchard Sts.

19 (a) MAR 30 1948 (Date rec'd by registrar) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29 1948, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-24 1948 to 3-28 1948, and that I last saw him alive on 3/27 1948

Immediate cause of death	Duration
Chronic Myocarditis	10 yrs
Due to Arteriosclerosis	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R Klerman M. D.
Address 3803 Edmondson Ave Date signed 3/29/48

VS 150

G61753

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G61753 Registered No. 122B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: 20-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 432 S. Payson Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Amelia Ebert

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1877

8. AGE: Years 70 | Months 4 | Days 14 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name August Ebert
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa
15. Birthplace Germany

16 (a) Informant Lula Pearl
(b) Address 432 S. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director George L. Schwab
(b) Address 2101 Pittsburgh Ave.

19 MAR 30 1948 (Date rec'd by registrar) (b) Funeraire for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1948, at 11:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 29 1948; to March 29 1948 and that I last saw h.e.r alive on March 29 1948.

	Duration
Immediate cause of death Respiratory Failure	3 hrs.
Due to Cerebral embolism	24 hrs.
Due to Post-operative	4 wks.
Other Conditions Pneumonitis, right (Include pregnancy within 3 months of death)	

Date of operation March 24 '48.
Major findings of operation: Adenocarcinoma of uterus & partial obstruction
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dillard M. Carouge M. D.
Address 4226 Everall Ave. Date signed 3-30-48

VS 150

X

661754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 661754 /125B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1401 N. DALLAS St
(c) Hospital or institution: 8-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1401 Dallas St
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME John W. CHAPPELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	C.	WIDOWED

6 (b) Name of husband or wife Alice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1858

8. AGE: Years	Months	Days	If less than one day
90			hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation JUNK DEALER

11. Industry or business

FATHER
12. Name ?
13. Birthplace Md

MOTHER
14. Maiden Name ?
15. Birthplace Md

16 (a) Informant CHARLES CHAPPELL
(b) Address 1401 N. DALLAS ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-31-48 (month) (day) (year)
(c) Cemetery or crematory MT. CALVARY
Location A.A. County, Md

18 (a) Funeral director Joseph L. Lock
(b) Address 1364 N. Central Ave

19 [illegible] 31 1948 (Date filed by Registrar) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 28 1948, at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/15 1948 to 3/28 1948
and that I last saw him alive on 3/28/1948.

Immediate cause of death	Duration
Bronchio Pulmonia	5 wks Daily
Hepatitis	
Due to Arterio-Sclerosis	Daily
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury

23. Signature Thos. R. Blake. M. D.
Address 1607 N. Caroline Date signed 3-30-48

VS 150

61755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 66755

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General 11-03
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 865 Linden Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Florence Chesley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 66 Months Days If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Wesley Wilson
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Phoebe Wilson
15. Birthplace Md

16 (a) Informant Wm. Chesley
(b) Address 865 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Joseph G. Locke Jr
(b) Address 1304 N. Central Ave

19 MAR 31 1948 (Date received by registrar) (b) Huntington Williams, M.D. (Registrar)

MAR 31 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/28/48 19 , at 11.05 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis, M.D. Medical Examiner.
Date signed 3/29/48

X

61756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. G61756

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 722 W. BARRE ST.
(c) Hospital or institution: 21-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 722 W. BARRE ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country —

3 (a) FULL NAME ISABEL L. FRENTZ

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife: CLAUS A. FRENTZ
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): AUG 19, 1878

8. AGE: Years	Months	Days	If less than one day
69	7	9	hr. min.

9. Birthplace: BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation: HOUSEWIFE
11. Industry or business —

FATHER
12. Name: ROBERT D. INNERST
13. Birthplace: BALTO, MD.

MOTHER
14. Maiden Name: ELIZABETH SHAWKER
15. Birthplace: MARYLAND

16 (a) Informant: MR. CLAUS A. FRENTZ (HUSBAND)
(b) Address: 722 W. BARRE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/31/48 (month) (day) (year)
(c) Cemetery or crematory: WOODLAWN
Location: BALTO. Co., MD.

18 (a) Funeral director: WM. J. TICKNER, SONS
(b) Address: BALTO., MD.

19 MAR 27 1948 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/27 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-12 1948 to 3-27 1948, and that I last saw h[illegible] alive on 3-27 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to Arteriosclerosis & Hypertension	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: ?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 876 Wilson St. Date signed 3/29/48

VS 150

661757 BC-48-06783 BALTIMORE CITY HEALTH DEPARTMENT 661757
CERTIFICATE OF DEATH 159 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens
(c) Hospital or institution: St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County U. L. A.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 824 Union Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Pueschel
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) 3/30/48

8. AGE: Years	Months	Days	If less than one day
			hr. 85 min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Ernest Pueschel
13. Birthplace Md.

MOTHER
14. Maiden Name Dorothy Kelly
15. Birthplace Md.

16 (a) Informant Ernest M. Pueschel
(b) Address 824 Union Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 31, 1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Paul E. Kenworthy Jr.
(b) Address 1615-17 Chestnut Ave.

19 (Date received by registrar) MAR 31 1948 Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/30/48 19 , at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 30 March 1948 to 30 March 1948, and that I last saw him alive on 30 March 1948.

Immediate cause of death Premature labor — Duration 5 3/4 mos.
Due to an fall one wk. ago
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. D. Elkins Sr. M. D.
Address St. Agnes Hosp. Date signed 3/31/48

VS 150

661758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

Registered No. 661758

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6714 Gary Ave
(c) Hospital or institution: Home 26-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto.-22 (If outside city or town limits, write RURAL and give town)
(d) Street No. 6714 Gary Ave. (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country FRANCE

3 (a) FULL NAME Joseph E. Thomas Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race White

6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Eugenia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1871

8. AGE: Years 76 Months 3 Days 2 If less than one day hr. min.

9. Birthplace France (Town, county, and state)

10. Usual Occupation Night Watchman

11. Industry or business Marshall Const. Co.

FATHER
12. Name Honore J. Thomas
13. Birthplace France

MOTHER
14. Maiden Name Ussule Beharel
15. Birthplace France

16 (a) Informant Joseph E. Thomas Jr.
(b) Address 6714 Gary Ave. Dundalk

17 (a) Wednesday (Burial, cremation, or removal) (b) Date thereof 3/31/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Baltimore, Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul Street

19 (Date received by registrar) MAR 31 1948 (Signature of Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1948 at 7:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1947 to March 1948, and that I last saw h[illegible] alive on March 26 1948.

Immediate cause of death Coronary Occlusion — Duration 2 hr.

Due to Arterio-Sclerotic Heart Disease — Duration 5 yrs.

Due to —

Other Conditions Bronchial Pneumonia — Duration 5 days

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Wm O Davis M.D.

Address Dundalk-22 Date signed 3/29/48

VS 150

G61759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

Registered No. G61759

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene Sts.

(c) Hospital or institution: University Hospital 26-10

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 143 So. Bouldin Street (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Robert Myrick

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 213-07-2982

4. Sex: M

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Florence E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): July 31, 1882

8. AGE: Years 65 | Months 7 | Days 28 29 | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: Electric Welder

11. Industry or business: Bethlehem Steel

FATHER

12. Name: Thomas Myrick

13. Birthplace: Virginia

MOTHER

14. Maiden Name: Mary Fryers

15. Birthplace: Baltimore, Md.

16 (a) Informant: Florence E. Myrick

(b) Address: 143 So. Bouldin Street

17 (a) Friday (Burial, cremation, or removal) (b) Date thereof 4/2/48 (month) (day) (year)

(c) Cemetery or crematory: Oak Lawn

Location: Baltimore, Md.

18 (a) Funeral director: William Cook Inc.

(b) Address: 1217 St. Paul Street

MAR 31 1948 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1948, at 11:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1948 to March 29 1948 and that I last saw him alive on March 29 1948.

Immediate cause of death: Lobar pneumonia, both lobes left.

Due to

Due to

Other Conditions: Arteriosclerosis, hypertrophy of prostate

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature: Lee Young Jr. M.D.

Address: University Hosp. Date signed 3/30/48

661760

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 661760

GM. 116342

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals. 26-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Months
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Balto
(c) City or town Baltimore GREGOR WAY
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 Garrison Blvd (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Geoghegan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Thelma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4 - 1903

8. AGE: Years	Months	Days	If less than one day
44	6	26	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Lambert Geoghegan
13. Birthplace MD.

MOTHER
14. Maiden Name Margaret McGlone
15. Birthplace MD.

16 (a) Informant Records B lto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Friday (Burial, cremation, or removal) (b) Date thereof 4/2/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul Street

19 (a) MAR 31 1948 (Date rec'd by registrar) (b) Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 30 - 1948, 5.00A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1- 5 - 1948 to 3 -30 - 1948, and that I last saw him alive on 3 - 30 - 1948.

Immediate cause of death	Duration
Tuberculosis, pulmonary, Bilateral, far advanced	
Due to with hemoptysis	years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp Date signed 3-30-48

VS 150

661761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

Registered No. 661761

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens Ave
(c) Hospital or institution: St Agnes Hospital -
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No. Summit Knoll
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Minnie W. Wood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married.

6 (b) Name of husband or wife Eugene H. Wood.
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) May 24 / 1914

8. AGE: Years	Months	Days	If less than one day
33	10	5	hr. min.

9. Birthplace Baltimore - (Town, county, and state)
10. Usual Occupation Home Wife
11. Industry or business

FATHER
12. Name Daniel L Donnelly
13. Birthplace Glenburnie Md

MOTHER
14. Maiden Name Margaret A. [illegible] Downes
15. Birthplace Glenburnie Md

16 (a) Informant Eugene H Wood
(b) Address Forest Knoll, Pasadena Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Memorial
Location

18 (a) Funeral director Charles J Powell
(b) Address 2427 Edmondson Ave Huntington Williams Md

MAR 31 1948 (Date rec'd by registrar)

Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-29-48 19 , at 2 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-24 1948 to 3-29 1948, and that I last saw h ex alive on 3-29- 1948.

Immediate cause of death	Duration
Cardiac failure -	
Due to Rheumatic C-V disease & mitral stenosis	
Due to exhaustion	
Other Conditions Gastric ulcer	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney J Venable Jr MD
Address St Agnes Hospital Date signed 3-29-48 M. D.

661762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

661762 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1037 N Carey Street
(c) Hospital or institution: 16-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1037 N. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie May Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Col	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/24/15

8. AGE: Years	Months	Days	If less than one day
33	3	3	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation H. W

11. Industry or business

FATHER 12. Name Frank Wolfarth

13. Birthplace B. W. I.

MOTHER 14. Maiden Name Florence Jefferson

15. Birthplace Md

16 (a) Informant Florence Wolfarth

(b) Address 1324 Smithson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-31-48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A. A. Co., Md

18 (a) Funeral director Isaiah L. Brown Sons

(b) Address 1049 W Monument St

19 MAR 31 1948 (Date filed by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 27 1948, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 3 1948, to Mar 15 1948, and that I last saw her alive on Mar 15 1948

Immediate cause of death	Duration
Pulmonary Tuberculosis	Undet.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. Harland Steinmetz Jr. M. D.

Address 902 W. Franklin Date signed 3-30-48

VS 150

X

C61763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

C61763
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Union 28-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4303 Chatham Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS BRODY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Jean
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Memphis Tenn
(Town, county, and state)

10. Usual Occupation Const Engineer

11. Industry or business

FATHER
12. Name Harry J Russia
13. Birthplace

MOTHER
14. Maiden Name Sarah
15. Birthplace England

16 (a) Informant Jean Brody
(b) Address 4303 Chatham Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-31-48 (month) (day) (year)
(c) Cemetery or crematory Sheerei Tfiloh
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc.
(b) Address 2100 Eutaw Place

19 MAR 31 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1948, at 11:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 16 1948 to March 29 1948, and that I last saw him alive on March 29 1948

Immediate cause of death	Duration
Myocardial Insufficiency	
Due to Chronic renal insufficiency	
" cardiac	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Mashbaum M. D.
Address Same Date signed 3-29-48

X

G61764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No. G61764

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 19-4
(b) Street address Raymond + Parkland St
(c) Hospital or institution:
West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
513 S Fulton ave
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 N Warwick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Nelson Hoffman Jr.

3 (b) If veteran, name war World War 2

3 (c) Social Security Account No. 212-20-7181

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth Zolkowski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12-1927

8. AGE: Years	Months	Days	If less than one day
20	10	18	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Chauffeur
11. Industry or business auto Parts

FATHER
12. Name Harry N. Hoffman Sr.
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Ella Young
15. Birthplace Balto. Md

16 (a) Informant Mrs Elizabeth Z Hoffman
(b) Address 513 S Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-48 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Balto. Md

18 (a) Funeral director Geo L. Bleyer Jr
(b) Address 151 N Holliday St

19 MAR 31 1948 (Date rec'd by registrar) Huntingtown Williams, Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1948, at 1 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Extensive infected burns, covering about 80% of body surface

Other Conditions Edema of lungs.
Necrosis of pancreas
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-25-48 at 4:40 P. M. 20/2
(b) Where did injury occur? Baltimore City Water Pure Co. 700 N. Warwick Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? yes
(d) Means of injury Stumbled into fire while burning trash

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 3-30-48

VS 151

X 399

G61765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 497

Registered No. G61765

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd Calvert

(c) Hospital or institution: Union Memorial Hosp 12-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....

(e) Length of stay in Baltimore (yrs., mos., or days) 22

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County .....

(c) City or town Homewood Apartments (If outside city or town limits, write RURAL and give town)

(d) Street No. ..... (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country .....

3 (a) FULL NAME ELEANOR M. GUEST

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Charles W. Guest

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 26 1869

8. AGE: Years	Months	Days	If less than one day
78	10	4	..... hr. ..... min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business .....

FATHER

12. Name William H Miller

13. Birthplace Balto, Md

MOTHER

14. Maiden Name Mary K Wayl

15. Birthplace Balto, Md

16 (a) Informant Hospital Record

(b) Address .....

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof May 31 1948 (month) (day) (year)

(c) ~~Cemetery or~~ crematory Green Mount

Location Balto, Md

18 (a) Funeral director Henry W. Jenkins Sons Co

(b) Address McCulloh & Richard Sts

19 (a) MAR 31 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-30 1948, at 4:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-8 1948 to 3-30 1948, and that I last saw her alive on 3-30 1948.

Immediate cause of death	Duration
Carcinoma of the vulva	+ 6 mos
Due to	.....
Due to	.....
Other Conditions Metastases to lungs (Include pregnancy within 3 months of death)	+ 2 wks

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)

(e) Means of injury .....

23. Signature J. A. Gregory, Jr. M. D.

Address Union Memorial Hosp Date signed 3-30-48

X

661766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 661766

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 106 Mt Clair St

(c) Hospital or institution: 18-3

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 106 Mt Clair St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** William L. Johnson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Widowed

6 (b) Name of husband or wife Susie T.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Unknown 1875

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Plasterer Self.

FATHER

12. Name William Johnson

13. Birthplace Baltimore Md.

MOTHER

14. Maiden Name Theodosia Pitch

15. Birthplace Baltimore Md

16 (a) Informant Mrs Charles W. Johnson

(b) Address 106 Mt Clair St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/48 (month) (day) (year)

(c) Cemetery or crematory London Park Cem

Location 3801 Frederick Ave

18 (a) Funeral director John J. Cowan & Son

(b) Address 901-03 Hollins St.

19 (a) MAR 31 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30th 1948, at 6.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-29-1948, to 3-30-1948, and that I last saw him alive on 3-29-1948.

Immediate cause of death	Duration
Arteriosclerotic Myocarditis	?
Due to Generalized Arteriosclerosis	?
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury —

23. Signature Wm. B. Ashenfelter M. D.

Address 5 E. Lexington Date signed 3-30-48

VS 150

X

661767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1931

Registered No. 661767

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2427 E Eager St
(c) Hospital or institution: 7-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2427 E Eager St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Emma L. Lang

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John F Lang

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 9 1861

8. AGE: Years 86 | Months 11 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER 12. Name George Lange

13. Birthplace Germany

MOTHER 14. Maiden Name Dorothea Kern

15. Birthplace New Jersey

16 (a) Informant Frederick J Lange

(b) Address 4805 Belgium Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 2 1948 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery

Location City

18 (a) Funeral director Hillrich Funeral Home

(b) Address 2008 Orleans St

MAR 31 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. **DATE OF DEATH** March 29th 1948, at 1 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 48 to March 29 1948 and that I last saw h. alive on March 27 1948

Immediate cause of death Hypertensive Heart Disease — Duration 2 4/5

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. Floyd Parrish M.D.

Address 800 N Dallas Ave Date signed March 30 1948

G61768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. G61768

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 20-1

(a) Baltimore City, Maryland

(b) Street address 2025 W. Fayette St

(c) Hospital or institution: Bon Secours Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County —

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 21 N Payson ST ; 23 (If rural give location)

(e) Citizen of foreign country? Yes (Yes or No)

If yes, name country Canada

3 (a) FULL NAME Frank Dailey "[redacted]" DALEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-4-89

8. AGE: Years 58 | Months 7 | Days 15 25 | If less than one day ... hr. ... min.

9. Birthplace Canada (Town, county, and state)

10. Usual Occupation Telegraph Lineman

11. Industry or business

FATHER 12. Name Frank Daley

13. Birthplace Canada

MOTHER 14. Maiden Name Helen Connors

15. Birthplace Canada

16 (a) Informant Mrs Ann Sullivan

(b) Address 1723 Baldwin Av - Detroit

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Md

18 (a) Funeral director F. B. Wisbert & Son

(b) Address 120 Eutaw Place

MAR 31 1948 (Date rec'd by Registrar) (b) Registrar Huntington Woollett, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-29 1948, at 3:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-28 1948 to 3-29 1948 and that I last saw him alive on 3-29 1948

Immediate cause of death Acute Congestion Failure — Duration

Due to — Duration: prob.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature George W. Fisher M. D.

Address Bon Secours Hosp Date signed 3-29

X

661769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. 661769

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3234 Elliott St.
(c) Hospital or institution: 26-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3234 Elliott St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mitchell J. Wiesner

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-14-3047

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Vera A. Leonard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1906

8. AGE: Years	Months	Days	If less than one day
42	2	27	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Merchant Marine
11. Industry or business

FATHER
12. Name Kasimir Wiesner
13. Birthplace Baltimore

MOTHER
14. Maiden Name not Known
15. Birthplace Baltimore

16 (a) Informant Wife
(b) Address 3234 Elliott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) 3-1 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 MARCH 1948, at 4:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 24 MARCH 1948 to 29 MARCH 1948, and that I last saw h/m alive on 27 MARCH 1948.

Immediate cause of death PULMONARY HEMORRHAGE — Duration 15 min.
Due to CHRONIC PULMONARY TUBERCULOSIS. — 4 yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Weinstein M. D.
Address 124 S. Wolfe St. Date signed 3/30/48

61770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. 61770

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A.
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 629 N. Central Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Postell

3 (b) If veteran, name war: WORLD WAR 1

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace LOUISIANA
(Town, county, and state)

10. Usual Occupation WATCHMAN

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant HENRY COOK
(b) Address 637 N. CENTRAL AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3 31 48 (month) (day) (year)
(c) Cemetery or crematory BALTO. NATIONAL CEM
Location BALTIMORE, MARYLAND

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St.

19 MAR 31 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29 1948, at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 3/29/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G61771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G61771

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 17.3
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 832 George Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Sterling

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1887

8. AGE: Years 60 Months 8 Days 21 If less than one day hr. min.

9. Birthplace Marion Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Thomas Sterling

13. Birthplace Md.

MOTHER 14. Maiden Name Annie Roache

15. Birthplace Md.

16 (a) Informant Bernice Williams

(b) Address 928 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 31 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Edmondson Ave

MAR 31 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-25- 19 48 at 7 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at A. M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature E. H. Royer M.D. Medical Examiner.

Date signed 3-26-48

VS 151

661772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. 661772

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 548 Wyanoke Ave

(c) Hospital or institution: 9-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 548 Wyanoke Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Carrie Nelson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married, widowed, or divorced.~~ (Married) Married

6 (b) Name of husband or wife Milton S. Nelson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2 1880

8. AGE: Years 68 | Months — | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER 12. Name George Engelmann

13. Birthplace Germany

MOTHER 14. Maiden Name Madeline Winkler

15. Birthplace Maryland

16 (a) Informant Madge Schley

(b) Address 548 Wyanoke Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 2 1948 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem

Location Belair Road

18 (a) Funeral director John G Mozan

(b) Address 3500 E Baltimore St

19 (a) MAR 31 1948 (Date received by registrar) (b) Burial Permit Issued

Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1948, at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15 1948, to 3-30 1948, and that I last saw her alive on 3/30 1948.

Immediate cause of death: Acute Cardiac Collapse — Duration: 1 da

Due to Pancreas & Stomach Cancer metastases — 6 mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Dr. Sigl J Lautsch M. D.

Address 679 N Eutaw, Balto 1 Md Date signed 3/31/48

X

G61773 ✓ G61773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1204 N. Gay St.
(c) Hospital or institution: 8.7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 N. Gay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irvin Reed

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15 1904

8. AGE: Years	Months	Days	If less than one day
44	-	14	hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Louis Reed

13. Birthplace Md.

MOTHER 14. Maiden Name Fannie Hopper

15. Birthplace Md.

16 (a) Informant Nettie Jeffries

(b) Address 1204 N. Gay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1 48 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Pk

Location Arbutus Md.

18 (a) Funeral director Mrs. Robt. A. Eckert, Daughter

(b) Address 1129 N. Caroline St

19 (a) APR 3 1948 (Date received by registrar) (b) Registration No. Wilmington, Williamsburg, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3. 29. 1948, at 6A. M

21. I certify that death occurred on the date above stated; that I attended deceased fr 3.24. 1948, to 3.29. 1948 and that I last saw h alive on 3.29 1948

Immediate cause of death Uremia — Duration 1 day

Due to Chr. cardio-renal vascular disease — Duration ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. A. Penny M. D.

Address 1420 E. Chase Date signed 3.30.48

VS 150

Dr Ralph Young

G61774

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

G61774 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2528 Woodbrook ave
(c) Hospital or institution: 13-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2528 Woodbrook ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Henry C Briscoe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Married

6 (b) Name of husband or wife Mary Briscoe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1906

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Thomas Briscoe
13. Birthplace maryland

MOTHER
14. Maiden Name Annie Briscoe
15. Birthplace maryland

16 (a) Informant Mary Briscoe
(b) Address 2528 Woodbrook ave

17 (a) Burial (b) Date thereof 3-31-1948 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Arbutus Mem. Cem.
Location Baltimore Md

18 (a) Funeral director Elroy D. Wilson
(b) Address 1010 Brantley ave

19 (a) MAR 31 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1948, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 1948 to March 28 1948 and that I last saw h. alive on March 26 1948

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions Cardiac Hypertrophy
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph J. Young M. D.
Address 1424 E Monument Date signed 3/30/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G61775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G61775 Registered No. 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 112 Cherrydale Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] Mr. Tipton Alonzo Hicks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (c) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mrs. Mary Hicks

6 (c) If alive, give [illegible] years

7. Birth date of deceased (mo., day, yr.) May 11, 1882

8. AGE: Years 65 | Months 10 | Days 18 | If less than one day: hr. min.

9. Birthplace Birmingham, Ala.
(town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Aircraft

FATHER
12. Name Bard Hicks
13. Birthplace Ala.

MOTHER
14. Maiden Name Mary Mollie Jacks
15. Birthplace Ala.

16 (a) Informant Mrs. Tipton Hicks
(b) Address 112 Cherrydale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/48 (month) (day) (year)

(c) Cemetery or crematory London Park
Location Baltimore City

18 (a) Funeral director Edward S. MacNabb
(b) Address Fred Wade & Co. Catonsville Md.

19 (a) 3620 (Local registration district number) (b) March 31 1948 Huntington, Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1948, at 3 15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 20 1948 to March 29 1948, and that I last saw h im alive on March 29 1948.

Immediate cause of death	Duration
Coronary Thrombosis	3 days
Due to	
Due to	
Other Conditions Hemorrhoidectomy	

(Include pregnancy within 3 months of death)

Date of operation 3-22-48

Major findings of operation:

of autopsy None granted

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature J. Robert Hasse M. D.
Address Church Home & Hosp. Date signed 3-29-48

VS 150

X

BC- C 66,887 — 661726 — 95c — 661726

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 18-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MICHELE Dale COATES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1947

8. AGE: Years	Months	Days	If less than one day
	7	28	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Richard Lexington
13. Birthplace Fairfield Md.

MOTHER
14. Maiden Name Belle Coates
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Lurgie Bryan
(b) Address 637-35th N.E. - Wash. D.C.

17 (a) Burial (b) Date thereof 3/31/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk.
Location Balto Co. Md.

18 (a) Funeral director Mrs. Lurgie B. Bryan
(b) Address 1631 Druid Hill Ave.

19 (a) MAR 29 1948 (b) Thomas J. Waters Registrar, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30/48, at 8:10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute dilatation of heart.
Acute pulmonary edema.
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature George G. Merrill M.D.
Medical Examiner.
Date signed 3/30/48

VS 181

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G61777

BALTIMORE CITY HEALTH DEPARTMENT 131a ✓ Registered No. G61777

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507 Laurens St.
(c) Hospital or institution: 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 Laurens St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Henry Meades

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Male | 5 Color or race Colored | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/10/1876

8. AGE: Years 72 | Months - | Days 19 | If less than one day hr. min.

9. Birthplace Riderwood, Md. (Town, county and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER 12. Name James Meades

13. Birthplace Md.

MOTHER 14. Maiden Name Lucy Berry

15. Birthplace Md.

16 (a) Informant Mrs. George A. Meades

(b) Address 529 Bruce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mrs. Edw. H. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) MAR (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1948, at 9:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 16 1948, to Mar 29 1948, and that I last saw him alive on March 29 1948.

Duration
Immediate cause of death: Coronary thrombosis
Due to: Cardiosclerosis, renal disease — 1 yr.
Due to: Arteriosclerosis
Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Burt H. Lindstrom M.D. M. D.

Address 523 Druid Hill Ave. Date signed 3-31-48

VS 150

G61778

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G61778
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy 5-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 336 Forest Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie DAVIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex f | 5. Color or race c | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 56 yrs. | Months | Days | If less than one day ____hr. ____min.

9. Birthplace nc (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace nc

MOTHER
14. Maiden Name Unknown
15. Birthplace nc

16 (a) Informant Venzella Waller
(b) Address 1822 E. Chase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A & A Co Md

18 (a) Funeral director Robert E Wilkins
(b) Address 1515 McCeddon St

19 (a) MAR 31 1948 (Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29/48 19____, at 9:00 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? X While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 3/29/48

AB-85306 661779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 661779

1-31-a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 9yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 716 West Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Micheal Moran--or--Michael Moran

3 (b) If veteran, name war

3 (c) Social Security Account No. 579-14-9977

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8-[illegible] 1880

8. AGE: Years	Months	Days	If less than one day
63	9	22	hr. min.

9. Birthplace England
(Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER
12. Name James Moran
13. Birthplace Ireland

MOTHER
14. Maiden Name Cecilia or Ceclia Hopkins
15. Birthplace England

16 (a) Informant Records--Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Frederick Rd

18 (a) Funeral director Edward Poulson
(b) Address 2359 west Blvd Balto 30 Md

19 (a) (Date received by registrar) (b) [illegible]

VSU 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1948, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-8- 1943 to 3-30- 1948 and that I last saw h[illegible] alive on 3-30- 1948

Immediate cause of death Confluent lobular pneumonia of upper & lower lobes L & R L.L.

Due to Organized mural Thrombosis

Due to Hypertensive Arteriosclerotic Cardiovascular Disease

Other Conditions Arteriosclerosis-Anemia
(Include pregnancy within 3 months of death)

Date of operation 10-2-47

Major findings of operation: Hemorrhoidectomy

of autopsy: None

Duration
days
8 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed 3-31-48

930

G61780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

477

G61780
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3506 Buck Ste
(c) Hospital or institution: 26-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3506 Buck Ste
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Frederick David Hartman Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Estelle C. Hartman
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Apr. 11 1894

8. AGE: Years	Months	Days	If less than one day
53	11	12 19	hr. min.

9. Birthplace Balto, Md
(Town, county, and state)
10. Usual Occupation Bricklayer
11. Industry or business

FATHER
12. Name Ambrose Hartman
13. Birthplace Germany

MOTHER
14. Maiden Name Dorothy Wagner
15. Birthplace Germany

16 (a) Informant Mrs. Estelle C. Hartman
(b) Address 3506 Buck Ste

17 (a) Burial (b) Date thereof Apr. 2-1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Locust Point
Location Broening Hwy & Sparrows Pt Rd

18 (a) Funeral director John B. Connelly
(b) Address 46 Eastern Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-30 1948, at 540 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8-1947 to 3-30 1948 and that I last saw him alive on 3-29 1948.

Immediate cause of death: Carcinoma of Rt. Lung — Duration: 9 Months
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation 11-18-47
Major findings of operation: Inoperable carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. J. Davidow M. D.
Address 3218 Eastern Ave Date signed 3/30/48

X

G61781

BALTIMORE CITY HEALTH DEPARTMENT ✓ G61781
CERTIFICATE OF DEATH 163H
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12-1
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 306 Suffolk Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald McCURLey ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Carrie McCoy McCurley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 17, 1882

8. AGE: Years	Months	Days	If less than one day
65	5	12	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Wallace Mc. Curley
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ellen J. Fales
15. Birthplace Balto Md

16 (a) Informant Mrs Helvetta Mc. Connell
(b) Address 306 Suffolk Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3601 Frederick Ave

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

MAR 31 1948 (Date rec'd by registrar) (b) Huntington Avenue, Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/31/48, 19..., at 8:45 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to Illuminating Gas

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/31/48 at 9 A.M.
(b) Where did injury occur? 306 Suffolk Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury Open gas burners of range

23. Signature John R Devi, M.D.
Medical Examiner.
Date signed 3/31/48

VS 151

G61782

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

55E

G61782
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 25-5
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1500 Spruce St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hollie Stewart, Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 6-24-44

8. AGE: Years 3 | Months 9 | Days 1 | If less than one day hr. min.

9. Birthplace W. Va (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Hollie Stewart

13. Birthplace W. Va

MOTHER 14. Maiden Name Blanche Smith

15. Birthplace W. Va

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 31/48 (month) (day) (year)

(c) Cemetery or crematory Brick Church Cem

Location Lost Creek W. Va

18 (a) Funeral director John O. Mitchell Sons

(b) Address 190 Eutaw Place

19 (a) (Date rec'd by registrar) Thurston Williams, Registrar

MEDICAL CERTIFICATION 45

20. DATE OF DEATH Mar - 30 1948, at 3 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-27-1948 to 3-30 1948 and that I last saw h[illegible] alive on 3-30-1948.

Immediate cause of death	Duration
Cardio Respiratory Failure	
Due to Central Nervous System Anoxia	2 hrs
Due to Cardiac Asystole	10 minutes
Other Conditions Chondrosarcoma Chest wall	

(Include pregnancy within 3 months of death)

Date of operation 30-Mar 48

Major findings of operation:

of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. L. Cantrell, M.D.
Address Johns Hopkins Hosp Date signed 30 Mar 48

To be approved by M.E., Howard J. Mueller, M.D.

G61783

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13/a

G61783 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 320 S. Exeter street
(c) Hospital or institution: 3-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 320 S. Exeter street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MICHAEL J. McMAHON

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	single

6 (b) Name of husband or wife ---
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 1, 1863

8. AGE: Years	Months	Days	If less than one day
84	11	27	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Martin McMahon
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Dunn
15. Birthplace Ireland

16 (a) Informant Mrs. Florence Keatts
(b) Address 320 S. Exeter street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans Son Inc
(b) Address 118 W. Mt. Royal Ave

19 (a) [illegible] (Date received by registrar) (b) [illegible] Registrar

MAR 31 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1948 at 4:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-26-1948 to 3-28-1948
and that I last saw h[illegible] alive on 3-28-1948

Immediate cause of death: Heart Valvular decompensation
Due to: Chronic nephritis
Due to: old age
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration: 5 days, years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. Duncan M. D.
Address Medical Arts Bldg Date signed

G61784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 64

Registered No. G61784

BC-C 96777

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15-09
(c) Hospital or institution: West Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3920 Bateman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stephen Wolfe 396777

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/11/47

8. AGE: Years	Months	Days	If less than one day
	3	19	hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Benj. Wolf
13. Birthplace Balto

MOTHER
14. Maiden Name Mary
15. Birthplace Balto

16 (a) Informant Father
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-31-48 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel
Location Southern Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 2100 Eutaw Pl
(c) Baltimore Md

MAR 31 1948 (Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1948, 3:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Status thymicolymphaticus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D. Medical Examiner.

Date signed 3-31-48

VS 151

G61785 Vol 2 N

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G61785 Registered No. 456201

122a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Garrison (If outside city or town limits, write RURAL and give town)
(d) Street No. Lyons Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fedelia Beckford

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 059-18-2193

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years: about 45 | Months | Days | If less than one day: hr. min.

9. Birthplace Jamaica St. Ann Bay. (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Andrew Beckford
13. Birthplace Jamaica. British W. Indies

MOTHER
14. Maiden Name Sophia Nembhard
15. Birthplace British West Indies

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 3-48 (month) (day) (year)
(c) Cemetery or crematory Long Island
Location New York.

18 (a) Funeral director Isaac A. Newell
(b) Address Pikesville, Md.

19 (a) 1948 MAR 31 Date rec'd by registrar (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/31 1948, at 4:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/31 1948 to 3/31 1948, and that I last saw her alive on 3/31 1948.

Immediate cause of death: Shock.
Toxemia
Due to Intestinal Obstruction
Due to Strangulated Internal Hernia (ileum) with gangrenous bowel

Duration

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 3-30-48

Major findings of operation: Dilated Small Bowel Gangrenous Hernia

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard D Brush
Address Johns Hopkins Hosp Date signed 3-31-48

HH. 3-E D 61786 + ✓ D 61786

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. [illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Allegany
(c) City or town Midland
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Catherine Beeman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 5/25/40

8. AGE: Years	Months	Days	If less than one day
7	10/11	11 6	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name James Beeman
13. Birthplace Md

MOTHER
14. Maiden Name Catherine Woods
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 4-1-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Cumberland, Md.

18 (a) Funeral director Wm J. Liebau & Sons
(b) Address 11 N. Penna Ave, Balto. Md

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/31 1948 at 2.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/27 1948 to 3/31 1948 and that I last saw her alive on 3/31 1948.

Immediate cause of death Cardio-respiratory failure — Duration immediate

Due to Cerebral degeneration

Due to Epilepsy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F. Crigler, Jr. M. D.
Address The Johns Hopkins Hospital Signed 5-3-48

VS 150

G61788 ✓ G61789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St
(c) Hospital or institution: Good Samaritan Home 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 236 N. Monroe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel A. Burns

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) Jan 28th 1860

8. AGE: Years	Months	Days	If less than one day
88	2	1	hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Alexander Burns
13. Birthplace Pa.

MOTHER
14. Maiden Name Rhoda A. Cubbison
15. Birthplace Pa.

16 (a) Informant W. P. Burns
(b) Address 236 N. Monroe St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/1/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) APR 1 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1948, at 4.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 28 1948, to March 29 1948, and that I last saw h. alive on March 29 1948.

Immediate cause of death Carcinoma of Bladder — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stelio Impresciutti M. D.
Address 27 North Carey St. Baltimore Md. Date signed 3/30/48

VS 153

Stelio Impresciutti

G61788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G61788

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital ~~or institution~~: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 606 W. Cross St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Weber L. Nash Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Carrie B. Nash

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1888

8. AGE: Years	Months	Days	If less than one day
59	6	5	hr. min.

9. Birthplace Culpepper Virginia (Town, county, and state)

10. Usual Occupation Boiler Maker

11. Industry or business

FATHER 12. Name Unknown Nash

13. Birthplace Virginia

MOTHER 14. Maiden Name Unknown Unknown

15. Birthplace Virginia

16 (a) Informant Carrie B. Nash

(b) Address 606 W. Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 3 48 (month) (day) (year)

(c) Cemetery or crematory Glen Haven

Location Catonsville Baltimore

18 (a) Funeral director Wm. Cook Jr.

(b) Address 125 E. Saratoga St.

19 (a) APR 1 1948 (Date rec'd by registrar) (b) Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-31 1948, at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/16 1948 to 3-31 1948, and that I last saw h alive on 3/31 19 48.

Immediate cause of death Coronary Thrombosis — Duration 1 da

Due to Coronary Disease — Duration 2 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Joseph L. Lowrance, M.D.

Address 6 W Washington B'd Date signed 3/31/48

VS 153

661789 ✓ 661789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. _____

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 N. Caroline Street 12
(c) Hospital or institution: St. Joseph's hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 75yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore 7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2412 Maryland Avenue (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3 (a) FULL NAME Mrs. Sarah A. Welling

3 (b) If veteran, name war _____ 3 (c) Social Security Account No. _____

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe.	White	Widow

6 (b) Name of husband or wife Walter
6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Sept 30th 1873

8. AGE: Years	Months	Days	If less than one day
74yr.	6	0	hr. _____ min. _____

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business _____

FATHER
12. Name Thomas Johnson
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Theodosia Fitch
15. Birthplace Baltimore, Md.

16 (a) Informant Allie Johnson
(b) Address 1615 Abbottston Street

17 (a) Friday (Burial, cremation, or removal) (b) Date thereof 4/2/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul Street

19 (a) APR 1 1948 (Date rec'd by registrar) _____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1948, at 3:45PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/28/ 1948 to 3/30/ 1948 and that I last saw her alive on 3/30/ 1948

Immediate cause of death	Duration
Asphyxiation	
Due to Cerebral hemorrhage	
Due to Hypertension A-S CVD	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation _____
Major findings of operations: _____
of autopsy: _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide _____
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury _____

23. Signature [illegible] M.D.
Address St. Joseph's Hosp. Date signed 4/1/48

VS 150

G61730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G61730 Registered No. 166

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 522 W. Barre St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lula Mae (Cook) Hawkins

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-07-5916

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Separated

6 (b) Name of husband or wife Thomas Hawkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16-1917

8. AGE: Years	Months	Days	If less than one day
30	9	13	hr. min.

9. Birthplace N. Carolina (town, county, and state)

10. Usual Occupation Factory work.

11. Industry or business

FATHER 12. Name Thomas Cook.

13. Birthplace N. Carolina

MOTHER 14. Maiden Name Mary Alston

15. Birthplace N. Carolina

16 (a) Informant William Cook

(b) Address 614 W. Lee St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 4 3 48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cemty

Location Balto.

18 (a) Funeral director Walter R. Sugar

(b) Address 134 W. Hamburg St.

19 (a) APR 1 1948 (Date received by registrar) Transcription from Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1948, at 12 25 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bullet wounds of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 3-29-48 at 12:10 A.M.

(b) Where did injury occur? 522 W. Barre St.

(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no

(d) Means of injury Gun Discharged

23. Signature [signature] M.D. Medical Examiner.

Date signed 3-29-48

VS 151

G61791

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93 ✓ G61794 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 942 Leadenhall St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Parker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name George W Forick
13. Birthplace South Carolina

MOTHER
14. Maiden Name Margret Forick
15. Birthplace S. Carolina

16 (a) Informant Herbert Forick
(b) Address 1919 Waverly St. S.C.

17 (a) (Burial, cremation, or removal) (b) Date thereof 4-1-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Lebanon Cemetery
Location Balto. Md.

18 (a) Funeral director Walter B. Spriggs
(b) Address 1894 Mt. Hamburg St. Baltimore, Md.

19 (a) (Date rec'd by registrar) APR 7 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/27 1948, at 3:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive C.V disease

Due to

Other Conditions Obesity

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed 3/29/48

VS 151

C61792

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1216

C61792 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 919 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Ida Francis Wagner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5 Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1919

8. AGE: Years 28 | Months 7 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Technician

11. Industry or business

FATHER 12. Name Allen A. Wagner

13. Birthplace Johnson City, Tenn.

MOTHER 14. Maiden Name Harriett Crawford

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Harriett Wagner

(b) Address 919 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/1948 (Month) (Day) (Year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mrs. Cecile G. Holland

(b) Address 1631 Druid Hill Ave. (Funeral home)

19 (a) Rec'd 4-1 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-29, 1948 at 1:55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 28 1948 to March 29 1948, and that I last saw h. alive on March 29 1948

Immediate cause of death: Renal Failure — Duration

Due to: Chronic Glomerulonephritis

Due to:

Other Conditions: Secondary Anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. H. Banfield

Address 722 N. Fulton Ave. Date signed 3/31/48 (M. D.)

VS 150

C61793 ✓ C61793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway + Fairmount
(c) Hospital or institution: Church Home + Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 dys
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balt. C. C
(c) City or town Baltimore 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1630 Gorsuch Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Allender.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Married.

6 (b) Name of husband or wife Charles Allender.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 1897?

8. AGE: Years	Months	Days	If less than one day
50 68	110	0	— hr. — min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Bussey,
13. Birthplace Maryland

MOTHER
14. Maiden Name Martin, Elizabeth
15. Birthplace Maryland.

16 (a) Informant Husband.
(b) Address 1630 Gorsuch Ave. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2, 1948 (month) (day) (year)

(c) Cemetery or crematory Reisterstown.
Location Reisterstown

18 (a) Funeral director Wm Berryman + Sons
(b) Address Reisterstown, Md.

19 (a) APR (Date rec'd by reg.) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1948, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 22 1948, to March 30 1948, and that I last saw her alive on March 30 1948.

Immediate cause of death	Duration
Coronary occlusion with Rupture of left Ventricle	2 yr.
Due to Arteriosclerotic heart	
Due to disease.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Kirk Moore MD
Address Church Home + Hospital Broadway + Fairmount Date signed 3-31-48
M. D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G61794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G61 [illegible] Registered No. 937

1. PLACE OF DEATH: 2624 Oswego Ave
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 da
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2624 Oswego Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Hankin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Hyman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years	Months	Days	If less than one day
86			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business House Wife

FATHER
12. Name Mayer Gorelick
13. Birthplace Russia

MOTHER
14. Maiden Name Rachel ?
15. Birthplace Russia

16 (a) Informant Samuel Hankin
(b) Address 3708 Towanda Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1, 1948 (month) (day) (year)
(c) Cemetery or crematory Sharrei Zion Cong Cem
Location Hamilton Ave Rosedale

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) APR 1 1948 (Date rec'd by registrar) (b) [signature] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1948 at 4.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 19 1945 to March 31, 1948 and that I last saw her alive on March 31, 1948.

Immediate cause of death: Arteriosclerotic Cardiac disease. — Duration: years.
Due to: Arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan H. Springfield M.D.
Address 1810 Eutaw Pl Date signed 4/1/48

X

G61795

BALTIMORE CITY HEALTH DEPARTMENT G61795 Registered No.

CERTIFICATE OF DEATH

122 B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Balto. General Hosp. 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 30 (If outside city or town limits, write RURAL and give town)
(d) Street No. 419 S. Hanover St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Harry Jacobson

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12, 1902

8. AGE: Years	Months	Days	If less than one day
46	1	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Brewery Employee

FATHER
12. Name Max Jacobson
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 1 48 (month) (day) (year)
(c) Cemetery or crematory Ohet Shalom Cemetery
Location O'Donnell Street

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1124-26 W. North Ave.

19 (a) Filed 1 1948 (Date received by Registrar) (b) Huntington Williams II Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1948 at 2 48 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/29 1948 to 3/31 1948. and that I last saw him alive on 3/31 1948.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Generalized peritonitis	
Due to Intestinal obstruction	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 3/21/48
Major findings of operation: Intestinal obstruction, Generalized peritonitis
of autopsy:

PHYSICIAN
Underline the cause to which (a) should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William B. Cogan Jr. M. D.
Address South Balto. Gen. Hosp. Date signed 3/31/48

VS 150

G61796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

G61796 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 401 N. Fulton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 401 N. Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph C. Moffett

3 (b) If woman, name war None

3 (c) Social Security Account No.

4 Sex Male | 5 Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Cora M. Moffett

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) January 4- 1879

8. AGE: Years 69 | Months 2 | Days 16 | If less than one day hr. min.

9. Birthplace Penn (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Thomas A. Moffett

13. Birthplace Ireland

MOTHER 14. Maiden name Margaret Mahathey

15 Birthplace N.C.

16 (a) Informant Cora M. Moffett

(b) Address 401 N. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 3-1948 (month) (day) (year)

(c) Cemetery or crematory Glen Haven M.G. Co. Md

Location

18 (a) Funeral director Pratt & Strickler & Co

(b) Address Washington, Md

19 Apr 1 1948 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1948, at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-29 1948 to 3-31 1948, and that I last saw him alive on 3-30 1948.

Immediate cause of death	Duration
Arteriosclerotic Myocarditis	?
Due to Generalized Arteriosclerosis	
Due to	
Other Conditions Bronchopneumonia	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. B. Schreiber M. D.

Address 54 S. Fulton Ave Date signed 3-31-48

VS 150

661797 48-06292

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1600

661797 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital ~~or Institution~~ St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days): 4da.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7603 South Bend Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hampshire

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23, 1948

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Hampshire
13. Birthplace ?

MOTHER
14. Maiden Name Margaret Olga Boleschak
15. Birthplace Baltimore

16 (a) Informant Hospital Record
(b) Address 1400 N. Caroline

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director L. J. Ryck
(b) Address 5305 Harford Rd.

19 (a) (Date filed by registrar) (b) Signature of Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27, 1948, at 9A. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 23, 1948, to March 27, 1948, and that I last saw him alive on March 27, 1948

Immediate cause of death CEREBRAL HEMORRHAGE — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E. Mray M. D.
Address 1400 N. Caroline Date signed

VS 150

St. X 4/1/48

C61798

BALTIMORE CITY HEALTH DEPARTMENT ✓ 108

CERTIFICATE OF DEATH

C61798 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1813 orlean St
(c) Hospital or institution: 6-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 orlean st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Mobley ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Chester S. C. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Chaney Mobley
13. Birthplace Chester S. C.

MOTHER
14. Maiden Name Harvey ?
15. Birthplace Chester S. C.

16 (a) Informant Adleap Wells
(b) Address 1813 orlean St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 3, 1948 (month) (day) (year)
(c) Cemetery or crematory St. Paul Cem.
Location Chester S. C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1005 Brookley ave Huntington Baltimore, Md.

19 (a) (Date received by registrar) (b) Registrar

APR 3 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-29- 1948, at 9:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-20 1948 to 3-29 1948, and that I last saw h[illegible] alive on 3-29 1948.

Immediate cause of death Lobar Pneumonia — Duration 2 wks.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard A. Rhoads M. D.
Address 2209 Druid Hill Ave Date signed 3-30-48

X

Obl 61799 ✓ G61799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 144915

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 25 S. Bond St (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Ida Harman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/19/1900

8. AGE: Years	Months	Days	If less than one day
48	-	9	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Harmon
13. Birthplace Georgia

MOTHER
14. Maiden Name Mary Jones
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn, Md

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Bloomfield ave

19 (a) [illegible] (b) [illegible] (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/28 1948, at 940 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/25 1948 to 3/28 1948 and that I last saw her alive on 3/28 1948.

Immediate cause of death	Duration
Renal failure	2wks
Due to Chronic pyelonephritis	+10yrs.
Due to	
Other Conditions Cirrhosis	25yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. E. Siggon
Address Johns Hopkins Hosp. Date signed 3 Apr 48 M. D.

VS 150

661800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 661800

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 115 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Hartinstein (HARTZENSTEIN)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Elevator Operator

11. Industry or business

FATHER
12. Name Morris
13. Birthplace Russia

MOTHER
14. Maiden Name Lena
15. Birthplace Russia

16 (a) Informant Benjamin Hartzenstein
(b) Address 319 Spruce St Phila Pa

17 (a) Burial (b) Date thereof 4-1-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Sheerei Tfiloh
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 2106 Eutaw Place

19 [redacted] Huntington Williams, M.D. Registrar
(Filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1948, at 11 P. M. 15

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl A. Ryon M.D.
Medical Examiner.
Date signed 3/30/48

VS 151

G61801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G61801 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3115 Woodland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3115 Woodland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marie Hooner

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: F. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Wi.

6 (b) Name of husband or wife: Elijah B. Hooner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept 28 1873

8. AGE: Years: 74 | Months: 6 | Days: 2 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Louis Weber
13. Birthplace: Germany

MOTHER
14. Maiden Name: Caroline Schneider
15. Birthplace: Germany

16 (a) Informant: Mrs. Elijah B. Hooner
(b) Address: 3115 Virginia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-48 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Park
Location: Woodlawn Maryland

18 (a) Funeral director: Lorenz Byers
(b) Address: 5005 Park Heights Ave.

19 (a) Date received by Registrar (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1948, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 14 1947 to Mar 30 1948 and that I last saw h[illegible] alive on Mar 30 1948.

	Duration
Immediate cause of death: Cerebral Hemorrhage	12/14/47
Due to: Diabetic Nephritis	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Chas D Bubert
Address 4803 Park Heights Ave Date signed 4/1/48 M. D.

X

C61802

BC-48-07766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

C61802 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Maryland & Rutland
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hrs
(e) Length of stay in Baltimore (yrs., moe., or days) 15 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3304 White Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy McCann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28 1948

8. AGE:

Years	Months	Days	If less than one day
0	0	0	15 hr. 45 min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Donald M. McCann
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Dorothy Kraft
15 Birthplace Balto. Md.

16 (a) Informant Mrs. Donald McCann
(b) Address 3304 White Ave.

17 (a) Burial (b) Date thereof 4-1-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore Md.

18 (a) Funeral director Lorenz Bros.
(b) Address 5001 Pk. Heights Ave.

(Date rec'd by Registrar) (b) Signature of Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1948, at 8 1/2 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 28, 1948, to March 29 1948 and that I last saw h/M alive on March 29 1948.

Immediate cause of death Cardio-respiratory failure — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Incomplete at this date.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stanley Steinberg M.D.
Address Sinai Hospital Date signed 3/30/48

G61803

BALTIMORE CITY HEALTH DEPARTMENT ✓ G61803
Registered No.

CERTIFICATE OF DEATH 55E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BEARDS RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 743 E. Cold Spring Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29-10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 743 E. Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mary Euler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John A. Euler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 27, 1863

8. AGE: Years	Months	Days	If less than one day
84	7	3	hr. min.

9. Birthplace Baltimore County, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

MOTHER / FATHER
12. Name John Henry Glenzer
13. Birthplace Germany
14. Maiden Name Wilhelmina Liebno
15. Birthplace Germany

16 (a) Informant Mr. Blaine E. Euler
(b) Address 743 E. Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Randallstown, Md.

18 (a) Funeral director Willis Lamond
(b) Address 4510 Liberty Heights Ave.

19 (a) 1948 (Date received by registrar) (Thurlington Williams, M.D.)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1948 at 6.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1st 1947 to March 30 1948 and that I last saw her alive on March 30 1948

Immediate cause of death	Duration
Carcinoma of Breast	4 months
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. C. Lamond M. D.
Address 4509 Liberty Hgts Ave Date signed

VS 150

X

G61804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1220a G61804 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument St.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Md Dead
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2517 Liberty Parkway.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin Janiszewski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	widowed

6 (b) Name of husband or wife Maryanna Janiszewska
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Charles Janiszewski
(b) Address 2517 Liberty Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 / 3 / 48 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Ave

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St. (Huntington Terrace, Md.)

APR 6 1948 (Date received by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-31-48 19 , at 8:40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 16 Mar 1948 to 31 Mar 1948, and that I last saw him alive on 31 Mar 1948.

Immediate cause of death	Duration
Post. mediastinitis	
Due to Perforation of esophagus	
Due to	
Other Conditions Left empyema Arteriosclerotic Cardiovascular Disease	

(Include pregnancy within 3 months of death)

Date of operation 16 Mar 48
Major findings of operation: Diaphragmatic hernia
of autopsy: Pending

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard H Batt M. D.
Address Sinai Hosp. of Balt. Date signed April 1, 1948

Registrar

VS 150

661805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

661805 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1022 S Linwood Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1022 S Linwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank J Dymowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-01-0234

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Married

6 (b) Name of husband or wife Stella Dymowski

6 (c) If alive, wife age 54 years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Peter Dymowski
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Stella Dymowski
(b) Address 1022 S. Linwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/48 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Ave

18 (a) Funeral director John J. Duda
(b) Address 2029 Hudson St (Funeral Director or Undertaker)

19 (a) APR 1 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-31-48, at 6.5 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-23-1948 to 3-31-48, and that I last saw h alive on 3-31-48

Immediate cause of death	Duration
Arteriosclerosis	3-23-48
Hypertension C. V. Disease	3-23-48
Cerebral Hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Ed Schmunk
Address 942 S Exeter Date signed 3-31-48

VS 150

G61806

BALTIMORE CITY HEALTH DEPARTMENT ✓ G61806
CERTIFICATE OF DEATH 94a
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3008 Clifton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3008 Clifton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John R. Saphar

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1873

8. AGE: Years	Months	Days	If less than one day
74	3	3	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name William D. Saphar
13. Birthplace N.Y.

MOTHER
14. Maiden Name Josephine Patterson
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Mabel A. Hall
(b) Address 3098 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Martin Zepp & Sons
(b) Address 1827 N. North Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

APR 1 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/30/48 19 , at 11:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30/48 19 to 3/30/48 19 , and that I last saw h alive on 3/30/48 19

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M D Bowers M. D.
Address 3033 W North Ave Date signed 3/31/48

v sbsd.

C61807

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. C61807

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 N. Montford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: John O'Brien Renner

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-03-4697

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14-1886

8. AGE: Years	Months	Days	If less than one day
64 53	11	15	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Glendenin Bros. Inc.

FATHER
12. Name Joseph Renner
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mary Wittig
(b) Address 621 N. Montford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1-48 (months) (days) (years)

(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave.

18 (a) Funeral director John G. Miller
(b) Address 2334 Jefferson St.

19 APR 1 1948 (Date rec'd by Registrar) (b) Huntington Williamsville, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1941, at 3 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Morrill M.D.
Medical Examiner.

Date signed 3-30-48

G61808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

G61808

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3113 Woodland Ave.
(c) Hospital or institution: at Home 21-16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3113 Woodland Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME James Joseph Gannon

3 (b) If veteran, name war: World War 1
3 (c) Social Security Account No. 215-07-8984

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Delia R. Gannon
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Oct-3-1893

8. AGE: Years 54 | Months 5 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Clerk-
11. Industry or business Mercantile Trust Co.

FATHER
12. Name Michael J Gannon
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Downs
15. Birthplace Ireland

16 (a) Informant Mrs Delia R. Gannon-wife-
(b) Address 3113 Woodland Ave-City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/m-3-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Sherwood Memorial Co.
(b) Address 1084 North Ave.

19 (a) 1948 (Date rec'd by registrar) Wellington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1948, at 5:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1944, to March 30 1948, and that I last saw him alive on March 29 1948.

Immediate cause of death	Duration
Coronary thrombosis	13 hr.
Due to Mitral regurgitation	1 yr.
Due to Hypertension	4 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. de Barbieri M. D.
Address 4723 Park Heights Ave. Date signed 3/31/48

VS 150

661809 ✓ 661805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1918 Bolton St.

(c) Hospital or institution: home 14-01

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs.+

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County —

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1918 Bolton St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No) NO
If yes, name country

3 (a) FULL NAME Rachel Healy Focke

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
None	None	Female	White	Widow

6 (b) Name of husband or wife Ferdinand B. Focke

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) JUNE 5 1858

8. AGE: Years	Months	Days	If less than one day
89	9	25	..... hr. ..... min.

9. Birthplace Philadelphia - Pa.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business "

FATHER

12. Name Charles Lehman

13. Birthplace Phila - Pa.

MOTHER

14. Maiden Name Sarah Earle Healy

15. Birthplace Phila - Pa.

16 (a) Informant Mrs. Frances S. Atkinson (Daughter)

(b) Address Roland Park Apt. - City - 10

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 04 - 2 - 48 (month) (day) (year)

(c) Cemetery or crematory Green Mount

Location Balto.

18 (a) Funeral director Stewart & Mowen Company

(b) Address 408 W. North Ave, City

APR (a) 1 1948 (b) Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 19 48 at 10 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 46 to March 19 48 and that I last saw her alive on March 30 19 48

Immediate cause of death Bronchopneumonia — Duration 4 days

Due to

Due to

Other Conditions Arteriosclerotic Cardio Vascular disease

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William J. Helfrich

Address 3705 Roland Ave Date signed 5/31/48 (M. D.)

VS 150

Balto - 10 107

G61810

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G61810 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St & Linden Ave.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 0
(e) Length of stay in Baltimore (yrs., mos., or days) life 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 311 Cathedral St., Apt. 2A (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Harry Fabian Goodrich

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 577-09-7276

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Agnes M. Goodrich

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr) Feb-7-1882

8. AGE: Years 66 | Months 1 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business: Clerk, A & P Stores Co.

FATHER
12. Name: Stephen C. Goodrich
13. Birthplace: St. Mary's Co., Maryland

MOTHER
14. Maiden Name: Emma J. Welch
15. Birthplace: St. Mary's Co., Maryland

16 (a) Informant: Mr. Harry F. Goodrich (self)
(b) Address: Wentworth Apts., City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr/3/48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Baltimore, Md.

18 (a) Funeral director: Stewart & Mowen Company
(b) Address: 108 W. North Ave., City #1

19 (a) ____ (Date received by registrar) (b) ____

APR 1 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 Mar 1948, at 7 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 26 Mar 1948, to 31 Mar 1948, and that I last saw him alive on 31 Mar 1948.

Immediate cause of death: Cardiac Failure — Duration: 5 days

Due to: Hypertensive Cardio-Vascular Disease — 10 yrs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Allan Smith, M.D.
Address: Med. Gen. Hosp. Date signed: 31 Mar 48

GG1811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

935

Registered No. GG1811

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1610 Eddon St.
(c) Hospital or institution: 25-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 Eddon St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martin Hanzely

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Julia Brier

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10 1871

8. AGE: Years	Months	Days	If less than one day
75	4	19	hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Shoe maker

11. Industry or business Self

FATHER
12. Name Not Known
13. Birthplace Austria

MOTHER
14. Maiden Name Not Known
15. Birthplace Austria

16 (a) Informant Mrs Julia Hanzely
(b) Address 1610 Eddon St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location B. & O.

18 (a) Funeral director C. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) 1948 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 29 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 27 1948 to Mar-29 1948, and that I last saw h[illegible] alive on March 29 1948

Immediate cause of death	Duration
Acute Cardiac Decompensation with Pulmonary Edema	1 day
Due to Arterio-Sclerotic Cardio-Vascular Disease	
Due to	
Other Conditions Arteriosclerosis Anemia - Senescence - 2 months	10 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Lubra M. D.
Address 320 Patapsco Ave Date signed 3/30/48

Huntington Williams M.D.

X

G61812

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

112

G61812

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balt. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Conn. (b) County
(c) City or town New Haven (If outside city or town limits, write RURAL and give town)
(d) Street No. 72 Asylum Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Jacob Murnick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Celia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Abe Bernblum
(b) Address 72 Asylum St New Haven Conn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-4-48 (month) (day) (year)
(c) Cemetery or crematory Ind. New Haven Lodge Cem
Location East Haven Conn

18 (a) Funeral director Jack Lewis Inc
(b) Address 2160 Cedar Place

19 (Date received by Registrar) APR 1 1948 Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1948, at 8 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchial Asthma

Due to

Other Conditions Chronic congestive Cardiac failure
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L Royle M.D. Medical Examiner
Date signed 4-1-48

G61813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G61813

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4328 N. Charles St.
(c) Hospital or institution: 27-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4328 N. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FRANK GEORGE SCHENUIT

3 (b) If veteran, name war -

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Hilda K. Schenuit
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1894

8. AGE: Years	Months	Days	If less than one day
53	4	12	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Pres.
11. Industry or business Schenuit Rubber Co.

FATHER
12. Name Alfons Schenuit
13. Birthplace Pittsburgh

MOTHER
14. Maiden Name Rosalie Dampmann
15 Birthplace Balto.

16 (a) Informant Mr. Edgar H. Spilman
(b) Address 4418 Wickford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem. Balto., Md.
Location

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 APR 2 1948 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 30, 1948, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947, to March 30 1948, and that I last saw h[illegible] alive on March 30 1948.

Immediate cause of death Cerebral embolus — Duration 2 hrs.
Due to Arteriosclerotic heart disease, with myocardial infarction and mural thrombi — ? 5 mos.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry F. Klemfuss Jr. M. D.
Address 1101 St. Paul St. Date signed April 1, 1948

C61814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. C61814

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave + Madison
(c) Hospital or institution: Maryland General Hospital 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Arundel Hotel, Charles + Mt Royal
(If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Herbert Stoner

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) ~~68~~ May 6, 1879

8. AGE: Years	Months	Days	If less than one day
68	10	25	hr. min.

9. Birthplace New York (town, county, and state)
10. Usual Occupation Retired
11. Industry or business Retired Dentist

FATHER
12. Name Dr. George W. Stoner
13. Birthplace a.

MOTHER
14. Maiden Name Sarah J. Myers
15. Birthplace Pa.

16 (a) Informant Mrs. Marian Hughey
(b) Address Littlestown, Pa.

17 (a) Removal for Burial (b) Date thereof April - 4 - 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cemetery
Location Littlestown, Pa.

18 (a) Funeral director J. M. Littlestown
(b) Address Littlestown, Pa. R.D.#4

19 APR 2 1948 Huntington Williams
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1948, at 5:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 1948, to April 1 1948, and that I last saw him alive on April 1 1948.

Immediate cause of death Shock

Due to Rupture of Subclavian Artery

Due to Generalized Carcinomatosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature O. Jens Hunt M. D.
Address Md Gen Hosp Date signed 4-7-48

G61815

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 55E

Registered No. G61815

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave & Madison St.
(c) Hospital or institution: Maryland General Hospital 269
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 Foster Avenue
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Slovak

3 (a) FULL NAME Mrs. Agnes Blum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or ~~wife~~ John Walter Blum
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 25, 1879

8. AGE: Years	Months	Days	If less than one day
69	2	5	hr. min.

9. Birthplace Slovak (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Peter Veystrk
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Mrs. Anna Trau - daughter
(b) Address 3908 Foster Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ St. Stanislaus Cemetery
Location Dundalk Rd. Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 (a) APR 2 1948 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1948, at 9:19 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 24 1948 to Mar 30 1948, and that I last saw her alive on Mar 30 1948.

Immediate cause of death Cardiac - Respiratory failure

Due to Generalized carcinomatosis

Due to

Other Conditions Hypertensive cardio-vascular disease.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature O. James Hunt M. D.
Address Maryland General Hosp Date signed 3/31/48

VS 153

X

G61816

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 513

G61816 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2146 Druid Park Drive
(c) Hospital or institution: 13-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 29 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2146 Druid Park Drive (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse Jr. Harris

3 (b) If veteran, name war —
3 (c) Social Security Account No. 214-03-1449

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary E. Harris
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 26-1872
8. AGE: Years 76 | Months 2 | Days 5 | If less than one day hr. min.
9. Birthplace Carroll Co. Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Levi Harris
13. Birthplace Maryland

MOTHER
14. Maiden Name Adaline —
15. Birthplace Maryland

16 (a) Informant Mrs. Mary E. Harris
(b) Address 2146 Druid Park Drive
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 3-1948 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge Memorial Park
Location Howard Co. Maryland
18 (a) Funeral director Burgee Funeral Home
(b) Address 2301 Falls Road Huntington Hollins, Md.
19 (c) APR 2 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1- 1948, at 6.30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1945 to 3/31 1948
and that I last saw him alive on 3/31 1948

Immediate cause of death: Renal dysfunction — Duration: hrs
Due to Carcinoma, prostate — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm N. Mathews Jr. M. D.
Address 1800 N. Charles St. Date signed 4/1/48

VS 151

X

G61817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G61817

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3640 Hickory Avenue
(c) Hospital or institution: 136
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3640 Hickory Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Gertrude Doublitz

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Harry A. Doublitz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22-1885

8. AGE: Years 62 | Months 5 | Days 9 | If less than one day hrs. min.

9. Birthplace Baltimore, Maryland (town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name John T. Dizen
13. Birthplace Maryland

MOTHER 14. Maiden Name Ida V. Miller
15. Birthplace Maryland

16 (a) Informant Harry A. Doublitz
(b) Address 3640 Hickory Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2-1948 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (Date rec'd by Registrar) APR 2 1948 (Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31- 1948, at 12-15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30 1948 to 3/31 1948, and that I last saw h.er alive on 3/31 1948.

Immediate cause of death Acute cardiac dilatation — Duration hrs.

Due to Arteria-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. N. McFaul Jr. M. D.
Address 1900 N. Charles St Date signed 3/31/48

VS 150

G61818 GEORGE W. HILBERG ✓ G61818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Cohoss Sts.
(c) Hospital or institution: Union Memorial Hospital 13-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. #11 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 W. 32nd St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME George W. Hilberg ✓

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-05-0523

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: Widower

6 (b) Name of husband or wife: Mary F. Mrs. G.W. Hilberg

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 3/8/72

8. AGE: Years 76 | Months 0 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Cotton Mill Worker

11. Industry or business

FATHER
12. Name John C. Hilberg
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary H. Foster
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Ella L. Ruby
(b) Address 3608 Roland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2-1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) APR 2 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/30/48 19..., at 2:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/14/48 19... to 3/30/48 19... and that I last saw him alive on 3/30/48 19...

Immediate cause of death: Bronchopneumonia
Etiology unknown — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel J. Bagley M. D.
Address Union Memorial Hospital Baltimore Md. Date signed 3/30/48

VS 150

X

C61819 GERTRUDE ESTELLE PIXON

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. C61819

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2724 N. Charles Street
(c) Hospital or institution: Doctor's Hospital 16-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 756 Edgewood Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Miss Gertrude Estelle Dixon

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-03-4771

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7-1876

8. AGE: Years 72 | Months 2 | Days 24 | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county and state)

10. Usual Occupation Seamstress

11. Industry or business

FATHER
12. Name George M. Dixon
13. Birthplace Maryland

MOTHER
14. Maiden Name Hannah M. Schmeck
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Mary E. Barnes
(b) Address 756 Edgewood Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5-1948 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Maryland

18 (a) Funeral director Durgee Funeral Home
(b) Address 3631 Falls Road

19 (a) Apr 2 1948 (Date rec'd by Local Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-1 1948, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1946 to 4-1 1948, and that I last saw her alive on 4-1 1948.

Immediate cause of death	Duration
Acute heart failure	
Due to Myocardegeneration	
Due to decompensated heart	
Other Conditions nephrosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H W Ukena M.D.
Address 3921 Edmondson Date signed 4/1/48

VS 150

Scheye 95c

G61820

BC G02463

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH / 170C

G61820
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians—please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1823 N. Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Veronica D. Bornman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/5/1944

8. AGE: Years	Months	Days	If less than one day
3	9	26	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Irvin Bornman
13. Birthplace Wash. D.C.

MOTHER
14. Maiden Name Helen Davis
15. Birthplace Baltimore

16 (a) Informant Mr. Irvin Bornman
(b) Address 1328 N. Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location "

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans st

19 APR 2 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1948, at 3:50 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions Multiple fractures

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-31-48 at 3:50 P.M.
(b) Where did injury occur? Hoffman & Washington Sts
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Pedestrian struck by auto

23. Signature Howard J. Mendelis M.D. Medical Examiner.
Date signed 4-1-48

G61821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G61821

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 25-1 D.O.A.
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 804 Primrose Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert L. Mercier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
M	W	Married

6 (b) Name of ~~husband or~~ wife Lillian M. Mercier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14th 1871

8. AGE: Years	Months	Days	If less than one day
77	2	17	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Night Watchman
11. Industry or business Eastern Overall Cleaning Co.

FATHER
12. Name Henry Mercier
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Lillian M. Mercier
(b) Address 804 Primrose Ave.

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 4/5/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) APR 2 1948 (Date rec'd by registrar) (b) Registrar Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/31 1948, at 3.20 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. S. Sulbrinke M.D. Medical Examiner.
Date signed 3/31/48

G61822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G61822

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Levindale 15-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1635 No Payson St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME BENJAMIN LEVY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible]

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace Newyork (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Ray Levy
(b) Address 1635 No Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-48 (month) (day) (year)
(c) Cemetery or crematory
Location: Hebrew Herzog Rym

18 (a) Funeral director Jack Lebow Inc
(b) Address 2100 Eutaw Place

19 (a) APR 2 1948 (Date rec'd by Registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-1 1948 at 7.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-8 1947 to 4-1 1948
and that I last saw h(im) alive on 4-1 1948

Immediate cause of death	Duration
Bronchopneumonia	
Due to Abdominal tumor	
Due to (over)	
Other Conditions	
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Vogel M. D.
Address Levindale Home Date signed 4-1-48

VS 150

61823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered 61823

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 632 N. Bruce St D.O.A.
(c) Hospital or institution: 16-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 632 N. Bruce St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arthur (Archie) Wright

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Sarah Wright

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23 1864

8. AGE: Years 83 | Months 7 | Days 4 | If less than one day hr. min.

9. Birthplace Essex Co. Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Arthur Wright Sr.
13. Birthplace Va.

MOTHER
14. Maiden Name unknown
15. Birthplace Md.

16 (a) Informant Lucretia Wright
(b) Address 632 N. Bruce St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/38 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary A. A. Co. Md
Location

18 (a) Funeral director Metropolitan Funeral Home Inc.
(b) Address 947 N. Mount St
(Date rec'd by registrar) (Huntington Ave Baltimore Md)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29 1938, at 12 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed 3/30/38

APR 2 1938

VS 151

X

G61824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G61824 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 14.3
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Mc Culloh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis Jacks

3 (b) If veteran, name war

3 (c) Social Security Account No. 461-12-6086

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/19/13

8. AGE: Years 32 | Months 0 | Days 10 | If less than one day hr. min.

9. Birthplace Miss, Louisiana (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant: Bessie Lee Freeman
(b) Address 2101 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/48 (month) (day) (year)
(c) Cemetery or crematory BATON ROUGE - Baton Rouge
Location Baton Rouge, La.

18 (a) Funeral director Charles R Lane
(b) Address 802 Madison Ave

19 (a) APR 2 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1948, at 5:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Embolus, Thrombophlebitis

Due to

Other Conditions Bullet wound of Chest, Bullet wound of abdomen

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-5-48 at 4:40 P.M.
(b) Where did injury occur? Pratt + Chapel St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Firearms

23. Signature [signature] M.D. Medical Examiner.
Date signed 3-31-48

G61825

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

Registered No. G61825

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14-3
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2115 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John A. Minor, Sr
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: Blanche Elise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-12-91

8. AGE: Years 57 | Months 1 | Days 19 | If less than one day hr. min.

9. Birthplace Virginia (town, county, and state)
10. Usual Occupation Waiter
11. Industry or business

FATHER
12. Name John Minor
13. Birthplace Va

MOTHER
14. Maiden Name Annie ?
15. Birthplace Va

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/48 (month) (day) (year)
(c) Cemetery or crematory Orbutus Mem. Pk.
Location Orbutus Md
18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.

APR 2 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1948, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/23 1948 to 3/30 1948 and that I last saw h alive on 3/30 1948

Immediate cause of death: UREMIA — Duration: ? 1 year

Due to Hypertensive Cardiovascular renal disease — ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas E. Van Metre M.D.
Address Johns Hopkins Hosp Date signed 3/31/48

X

G61826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

Registered No. G61826

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Jail Dept
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Hartsville (If outside city or town limits, write RURAL and give town)
(d) Street No. P.O. Box 747 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1924

8. AGE: Years 24 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

Send Burial Permit to Undertaker

16 (a) Informant:
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-6-48 (month) (day) (year)
(c) Cemetery or crematory Hartsville
Location Hartsville, S.C.

18 (a) Funeral director Charles L. Law
(b) Address 802 Madison Ave Furniture Dealers Williamsport, Md.

19 APR 2 1948 (Date rec'd by Registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1948 at 9 00 P M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to hanging

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-30-48 at 9:00 P M.
(b) Where did injury occur? Baltimore City Jail
(c) Did injury occur at home, on farm, industrial place, in public place? Jail While at work? no
(d) Means of injury Hanged self by belt from cell door

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed 3-31-48

G61827

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 108

Registered No. G61827

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1010 Bennett Place
(c) Hospital or institution: 18-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 Bennett Place (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME JOHN W. NORRIS

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Florence

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 3/27/1868

8. AGE: Years: 80 | Months: 0 | Days: 2 | If less than one day: ____ hr. ____ min.

9. Birthplace A.A.County, Md. (Town, county, and state)

10. Usual Occupation: Unemployed

11. Industry or business

FATHER
12. Name: Henry Norris
13. Birthplace: A.A.County, Md

MOTHER
14. Maiden Name: Margaret
15. Birthplace: A.A.County, Md

16 (a) Informant: James Norris
(b) Address: 215 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn
Location: Baltimore, Md

18 (a) Funeral director: Charles C. Cooper
(b) Address: 510-12 N. Carrollton Ave.

19 (a) APR 2 1948 (Date rec'd by registrar) (b) Huntington-Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29/48 19____, at 1:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24 1948, to 3/29 1948, and that I last saw h[illegible] alive on 3/29 1948

Immediate cause of death: Myocardial Failure — Duration

Due to: Lobar Pneumonia

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: [illegible]

Address [illegible] Date signed 4/1/48 M.D.

C61828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. C61828

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 102 N. Poppleton St.
(c) Hospital or institution: 18-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 N. Poppleton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche Carter Mainer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Married

6 (b) Name of husband or wife Edward Mainer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1887

8. AGE: Years	Months	Days	If less than one day
60	5	7	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Albert Carter
13. Birthplace Ga

MOTHER
14. Maiden Name Mary Powell
15. Birthplace Va

16 (a) Informant Gladys Wilson
(b) Address 102 N. Poppleton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) APR 2 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1948 at 2.25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1948 to April 1 1948 and that I last saw him alive on April 1 1948

Immediate cause of death

Cardio-Renal — Duration 2

Due to — Duration 2 Mo

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. J. Fletcher M. D.
Address 1725 Eutaw Date signed 4/7/48

VS 150

C 1829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

Registered No. 1829

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 425 N. Stricker St.
(c) Hospital or institution: 19-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 425 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Perry Brown.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	married

6 (b) Name of husband or wife Annie Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 14, 1872

8. AGE: Years	Months	Days	If less than one day
75	5	14	hr. min.

9. Birthplace Frederick County, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Samuel Brown,
13. Birthplace Md.

MOTHER
14. Maiden Name Jemima
15. Birthplace Md.

16 (a) Informant Annie Brown.
(b) Address 425 N. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 2, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (d) APR 2 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-28 1948, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-2-1948 to 3/4 1948 and that I last saw h.... alive on 3-27-1948

Immediate cause of death	Duration
Chronic Cardio-Vascular Renal Disease. Carcinoma prostate & metastases	1 year
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. Carman M. D.
Address 600 Madison Ave

3/31/48

VS 150

G61830

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 183a

X G61830 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 116 KOLB AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Iola M. Lehman — IOLA M. LEHMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Mr. Jesse Lehman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 21 - 1883

8. AGE: Years	Months	Days	If less than one day
64	10	10	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name JOHN G. WAGNER
13. Birthplace BALTIMORE

MOTHER
14. Maiden Name MARY RUPPERT
15. Birthplace BALTIMORE

16 (a) Informant [redacted] Jesse B Lehman
(b) Address 116 KOLB. ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood.
Location Taylor. ave.

18 (a) Funeral director Clarence P. Hoffman
(b) Address 1639 Aisquith

19 APR 2 1948 (Date rec'd by registrar) (b) Huntington Williams Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 19 48, at 9:16 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 29 19 48 to March 31 19 48 and that I last saw h[illegible] alive on March 31 19 48.

Immediate cause of death	Duration
Coronary Occlusion	
Due to Cerebral Vascular accident	
Due to	
Other Conditions Chron. Abd. malignancy	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William F. Carr M. D.
Address Bon Secours Hosp. Date signed 3-31-48

VS 150

X

G61831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G61831

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1215 N. Central Ave
(c) Hospital or institution: 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1215 N. Central Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank W. G. Roberts

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-07-8171

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	C.	MARRIED

6 (b) Name of husband or wife Flossie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1907

8. AGE: Years	Months	Days	If less than one day
40	4	12	hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Bethlehem Steel Co

FATHER
12. Name Henry Roberts
13. Birthplace S. C.

MOTHER
14. Maiden Name Janie Goods
15. Birthplace S. C.

16 (a) Informant Flossie Roberts
(b) Address 1215 N. Central Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County, Md.

18 (a) Funeral director Joseph S. Lockard
(b) Address 1130 N. Central Ave
(b) Huntington Nellinger Md
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/31 1948 at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/10/44 19 to 3/31 19 48 and that I last saw h[illegible] alive on 3/30 19 48.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 4 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rayner Browne
RAYNER BROWNE, M.D.
Address 1500 EAST MADISON ST. Date signed 4/2/48
BALTIMORE 5, MD.

VS 150

G61832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. G61832

The PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert Sts 9-6
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 18 Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 East 28th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William R. Nizer (WILLIAM RICHARD NIZER)
3 (b) If veteran, name war: No
3 (c) Social Security Account No. 218-01-0282

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or divorced.
M	W	M

6 (b) Name of husband or wife Eleanora Nizer
6 (c) If alive, give age 64 years
7. Birth date of deceased (mo., day, yr) February 20, 1883.

8. AGE: Years	Months	Days	If less than one day
65	1	12 11	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business — Retired

FATHER
12. Name John L. Nizer
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Appel
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Eleanora Nizer- W
(b) Address 1626 E. 28th. Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE & BROADWAY

19 APR 7 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1948, at 5.54 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 30 1948 to April 1 1948 and that I last saw h in alive on 3-31 1948.

Immediate cause of death Congestive Heart Failure — Duration 1 year
Due to Secondary Anemia — 1 year
Due to Acute Exacerbation of Chronic Myelogenous Leukemia — 2 weeks
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Smith, Jr. M.D.
Address Union Memorial Hospital Date signed 4/1/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

661833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 661833

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22-1
(c) Hospital or institution South Balto. Genl Hospital DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 833 Light St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Marvin Bobbitt Alexander M. Bobbitt

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife. Sallie M. Bobbitt

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1876

8. AGE: Years 71 | Months 3 | Days 15 | If less than one day: hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Dentist

11. Industry or business

FATHER
12. Name Rev. James B. Bobbitt
13. Birthplace North Carolina

MOTHER
14. Maiden Name Mary Miller
15. Birthplace North Carolina

16 (a) Informant Mrs. Sallie M. Bobbitt - W
(b) Address 833 Light Street, Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/48 (month) (day) (year)
(c) Cemetery or crematory Church Hill
Location Church Hill, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) APR 2 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1st 1948, at 12.05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work
(d) Means of injury

23. Signature W. J. McGuckin M.D.
Medical Examiner.
Date signed 4/1/48

GG1834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No. GG1834

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 615 E. Chase St
(c) Hospital or institution: 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 E. Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Irene Canby Meyers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Theodore Meyers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1888

8. AGE: Years	Months	Days	If less than one day: hr	min
59	6	4		

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Winfield S. Canby
13. Birthplace Baltimore

MOTHER
14. Maiden Name Annie Affeyroux
15. Birthplace Baltimore

16 (a) Informant Blanche Canby
(b) Address 615 E. Chase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 5, 1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St

19 Date received APR 2 1948 Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 April 1948 at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 17 March 1948 to 1 April 1948 and that I last saw h[illegible] alive on 1 April 1948.

Immediate cause of death: pulmonary edema — Duration: 2 days
Due to: aortic stenosis — ?
Due to: arteriosclerosis — ?
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Samuel Klemperer M.D.
Address 714 E. Preston Date signed 2 Apr. 48

X

G61835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G61835 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1723 E. Biddle
(c) Hospital or institution: 8-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1723 E. Biddle (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Susie Andrews

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Morris Andrews | 6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) March 6th 1896

8. AGE: Years 52 | Months - | Days 24 | If less than one day hr. min.

9. Birthplace Crisfield Md. (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER: 12. Name Joseph Hall | 13. Birthplace Va.

MOTHER: 14. Maiden Name Millie Stirling | 15. Birthplace Md

16 (a) Informant Morris Andrews
(b) Address 1723 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-1948 (Month) (Day) (Year)
(c) Cemetery or crematory Mt Calvary
Location C. & C. Co. Md.

18 (a) Funeral director Byron Magruder Wright
(b) Address 721 Valiant St

19 APR 2 1948 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1948, at 2:00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 9 1948, to March 30 1948; and that I last saw her alive on March 28 1948.

Immediate cause of death
(a) Pericardial Effusion
Due to (b) Pulmonary Emphysema
Due to
Other Conditions Cardio-renal Disease
(Include pregnancy within 3 months of death)

Duration
8 wks
1.
2

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. E. White M. D.
Address 1422 Eutaw Pl. Date signed 4/1/48

V.S. 151

107

S-61836 S-61836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 925

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.I.
(b) Street address
(c) Hospital or institution South Balto General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Rural-Near Annapolis
(If not in city or town incorporated, write RURAL and give town)
(d) Street No. Dogwood Rd-Lombardy Beach (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth M. Cross.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6. (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Paul Cross.

6 (c) If alive, give age — years

7. Birth date of decreased (mo., day, yr.) March 17-1891

8. AGE: Years 57 Months 0 Days 14 If less than one day hr. min.

9. Birthplace Baltimore-Md. (Town, county, and state)

10. Usual Occupation Practical Nurse.

11. Industry or business

FATHER
12. Name William Jones.
13. Birthplace Unknown.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Unknown.

16. (a) Informant Mrs. Walter Beckstrom.
(b) Address 101 Dogwood Rd-Lombardy Beach.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April-3/48. (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery.
Location Baltimore-Md.

18. (a) Funeral director Charles J. Schwab.
(b) Address 3512-Frederick Ave.

19 APR 2 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/31 1948 at 5:21 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to h-r death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. LaRumbe M.D.
Medical Examiner.
Date signed 4/5/48

VS 191

OC = 48-00333

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. G61837

CERTIFICATE OF DEATH 104a

G61837

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave.
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town (If outside city or town limits, write RURAL and give town) Baltimore - 5
(d) Street No. 527 N. Glover Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leo Emil Majchrzak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 2, 1948

8. AGE: Years | Months 3 2 | Days | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

MOTHER FATHER

12. Name John A. Majchrzak

13. Birthplace Baltimore Md

14. Maiden Name Carol Summers

15. Birthplace GLENVILLE W. Va.

16 (a) Informant John A. Majchrzak

(b) Address 527 N. Glover Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-48 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Baltimore, Maryland

18 (a) Funeral director George A Weller

(b) Address 706 S Amity st.

19 (a) APR 2 1948 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-1- 1948 at 7:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Upper Respiratory Infection

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Carl H Rogers M.D. Medical Examiner

Date signed 4-2-48

VS 181

G61838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

Registered No. G61838

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 12-3
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2464 Brentwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Thornton
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race Colored
6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Willie
6 (c) If alive, give age 47 years
7. Birth date of deceased mo., day, yr 10-23-1900
8. AGE: Years 47 Months 5 Days 1/2 If less than one day hr. min.
9 Birthplace Do. Car. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Tode Pride
13. Birthplace S.C.

MOTHER
14. Maiden name Katie Purnett
15. Birthplace S.C.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem. Location A. A. County Md
18 (a) Funeral director Mr. Gott O. Elliott Dft
(b) Address 1129 N. Carlton St.
APR 2 1948 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-29-48 at 7P M
21. I certify that death occurred on the date above stated; that I attended deceased from 3-21-48 to 3-29-48 and that I last saw her alive on 3-29-48.

	Duration
Immediate cause of death: Ruptured dissecting aneurysm of aorta	20 min.
Due to: arteriosclerosis, generalized	
Due to: hypertensive cardio-vascular disease	+10 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: the above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Sisson M. D.
Address Johns Hopkins Hosp. Date signed 3-30-48

X

G61839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

G61839

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland 19-H

(b) Street address 1620 W. Lexington St.

(c) Hospital or institution: Maryland Baptist Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL, and give name of county)

(d) Street No. 1620 W. Lexington St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Nellie Ann Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: James A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8, 1869

8. AGE: Years: 78 | Months: 11 | Days: 22 | If less than one day: hr. min.

9. Birthplace: Savannah Ga. (Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER

12. Name: John A Wooling

13. Birthplace: Va.

MOTHER

14. Maiden Name: Nellie A.

15. Birthplace: Va.

16 (a) Informant: Records - Home

(b) Address 1620 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/1948 (month, day, year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director: Mrs. Geo. H. Holland

(b) Address 1631 David Hill Ave

19 (a) 4-2-1948 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/30/1948 2:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6/1948 to 3/29/1948 and that I last saw h[illegible] alive on 3/29/1948.

Immediate cause of death: Cerebral Hemorrhage

Due to: Apoplexy

Due to:

Other Conditions: Hemiplegia Left side

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: Yrs. Mos. Days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. K. Barksdale M. D.

Address 5214 Cary St Rd Date signed 3/31/48

G61840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G61840 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2415 Arunah ave
(c) Hospital or institution: 165
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2415 Arunah ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Pantelis N. Katselis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Filio

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr) 1873

8. AGE: Years	Months	Days	If less than one day: hr.	min.
75	-			

9. Birthplace Turkey (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Nick
13. Birthplace Greece

MOTHER
14. Maiden Name ?
15. Birthplace Greece

16 (a) Informant Daughter
(b) Address 2415 Arunah ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-2-48 (month) (day) (year)
(c) Cemetery or crematory Greek Cemetery
Location Wimbledon Mill Rd

18 (a) Funeral director Lambros Funeral Home Inc
(b) Address 438-440 E. North ave

19 (a) (Date received by registrar) (b) Registrar

APR 2 1948

FORM VS 155

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1945, at 7:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/15 1944 to 3/31 1945 and that I last saw h/M alive on 3/24 1945.

Immediate cause of death	Duration
Congestive Heart Failure	6 Mos
Due to Arteriosclerotic Cardio-Vascular Disease	5 Yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]

Address 2629 Edmondson Date signed 4/6/45 (M/D)

X

G61841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G61841
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2905 Brighton St.
(c) Hospital or institution: 16-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2905 Brighton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Birdie V. Zeitler

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25th 1873

8. AGE: Years 74 | Months 4 | Days 6 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation House Work
11. Industry or business at Home

FATHER
12. Name Henry Jones
13. Birthplace England

MOTHER
14. Maiden Name Sahra V. Eyerly
15. Birthplace Md.

16 (a) Informant Mr Henry C. Wootton
(b) Address 2905 Brightonst.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/48 (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location 3801 Frederick Ave

18 (a) Funeral director John J. Cowanesdon
(b) Address 9003 Hollins St.

19 (a) Apr 8 1948 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31st 1948, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1948 to Mar. 31 1948 and that I last saw her alive on Mar. 31 1948.

Immediate cause of death CARDIAC FAILURE

Due to ARTERIOSCLEROTIC C.V.D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Torrence M
Address 3325 Frederick Ave Date signed 4/1/48

X

G61842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

G61842 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. 135 N. Exeter St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alexander Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8, 1905

8. AGE: Years	Months	Days	If less than one day
42	11	19	hr. min.

9. Birthplace Middlesex, Virginia (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name John H. Baker
13. Birthplace Middlesex Virginia

MOTHER
14. Maiden Name Anna Cook
15. Birthplace Middlesex Virginia

16 (a) Informant Edna Redding
(b) Address 1316 Ashland Ave.

17 (a) Burial (b) Date thereof 4 2 48 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Calvary
Location U.A. Country

18 (a) Funeral director Rayner, Sandra
(b) Address 1412 E. Preston St.

APR 2 1948 (a) (Date rec'd by registrar) (b) Huntington Williams Mortuary

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-27-1948 at 6 03 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute congestive heart failure, Hypertrophy of the heart, acute fatty liver, Edema and Congestion of lungs, and ~~Other Conditions~~ Edema of brain.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Thomas J. Mackin, M.D. Medical Examiner.
Date signed 3/29/48

VS 191

G61843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G61843
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 S. Regester St
(c) Hospital or institution: 2-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 212 S. Regester St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna F. Crispen (or) Crispens

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife John W.
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr Sept 12 1882

8. AGE: Years 65 | Months 6 | Days 19 | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Janitress

11. Industry or business

FATHER
12. Name Louis Friedel
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Germany

16 (a) Informant Joseph F. Friedel
(b) Address 5 N. Curley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 3 '48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park National
Location 3145 Frederick Rd

18 (a) Funeral director Dippel Bros
(b) Address 1800 E. Lombard St

APR 2 1948 (Date rec'd by registrar) Huntington Williams (5)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1948, at 6A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1947 to April 1 1948, and that I last saw h[illegible] alive on March 26 1948.

Immediate cause of death: General Arteriosclerosis — Duration 3 yrs
Due to Chronic Myocarditis — 3 yrs
Due to Coronary Thrombosis — 1 day

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Milton L. Solomon
Address 129 S Bway Date signed 4/2/48

VS 150

G61844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 109a

G61844

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4210 Hayward Avenue
(c) Hospital or institution: 28-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4210 Hayward Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith Marie Samosuk or Marie Edith Samosuk ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Wm. L. Samosuk
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1906

8. AGE: Years	Months	Days	If less than one day hr.	min.
41	7	15 17		

9. Birthplace Richmond, Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name Wm. P. Devine
13. Birthplace Connecticut

MOTHER
14. Maiden Name Beatrice Schwab
15. Birthplace New Jersey

16 (a) Informant Wm. L. Samosuk
(b) Address 4210 Hayward Ave., Balto., Md.

17 (a) Burial (b) Date thereof 4-3-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John A. Gerbliauckas, Jr.
(b) Address 423 S. Paca Street, Balto., Md.

19 (a) Date received by Registrar APR 3 1948 (b) Registrar Huntington Williams, M.D.

VS-8

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1948, at 5- A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1, 1947 to April 1, 1948, and that I last saw her alive on March 31 1948

Immediate cause of death	Duration
Virus Pneumonia	4 mos.
Due to	
Due to	
Other Conditions General Asthenia	1 mo.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature E E Nichols M. D.
Address Pikesville, Md. Date signed 4-1-48

T

G61845

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 197

G61845
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4713 Norwood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4713 Norwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT C. CLARK

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widower

6 (b) Name of husband or wife Mary H. Clark
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr April 20, 1863

8. AGE: Years	Months	Days	If less than one day
84	11	11	hr min

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Retired B. & O. R. R.
11. Industry or business

FATHER
12. Name John H. Clark
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Gray
15. Birthplace Maryland

16 (a) Informant Mr. Carroll H. Clark
(b) Address 4713 Norwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. FICKER & SONS
(b) Address Balto., Md.

19 (a) Date received by registrar APR 2 1948 Lemuel Williams, M.D. Registrar

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 31, 1948 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 to March 31 1948
and that I last saw him alive on 3/30/48 19

Immediate cause of death	Duration
Carcinoma	1 mo.
Due to Senility	4 yrs.
Due to Hypertension	4 yrs.
Other Conditions Arteriosclerosis	6 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Geo. E. Walker M. D.
Address 4100 Edmondson Ave. Date signed 4/1/48

102

G61846

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 170 C

G61846 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 26-4
(b) Street address
(c) Hospital or institution: West Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 118 Quantrill Way (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ada Hardy

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 6, 1872

8. AGE: Years	Months	Days	If less than one day
76	0	25	hr min

9. Birthplace Balto Co. Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Wm. Meeks
13. Birthplace England

MOTHER
14. Maiden Name Mary Ann Earle
15. Birthplace Balto Co. Md.

16 (a) Informant Mrs. Mary E. Schmidt
(b) Address 4009 Southern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/48 (month)
(c) Cemetery or crematory Maryland Mem. Gdns.
Location Balto Co. Md

18 (a) Funeral director Wm. J. Fickey & Son
(b) Address Baltimore Md.
Huntington Williams Md

19 (Date received by registrar) APR 2 1948

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1948 at 5 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fracture of pelvis.
Fracture of both bones of both lower legs.
~~Due to~~ Fractured ribs.
Contusion of brain.

Other Conditions Generalized arteriosclerosis.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-26-48 at 6:30 P.M. 28/1
(b) Where did injury occur? Restaurant Rd. Granada Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 4-1-48

G61847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G61847
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The space right is especially important. Physicians—please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 to 740 W Street
(c) Hospital or institution: Home for Incurables 13-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. and 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give name)
(d) Street No. Tudor Arms Apartments
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Harold Holtz

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Wh	

6 (b) Name of husband or wife
6 (c) If widow, give age years

7. Birth date of deceased (mo., day, yr.) Oct 6, 1884

8. AGE: Years	Months	Days	If less than one day
63	5	24	hr. min.

9. Birthplace Baltimore
(State, country, and city)

10. Usual Occupation
11. Industry or business

12. Name Charles John H. Holtz
13. Birthplace Baltimore Md

14. Maiden Name Emma Doris Young
15. Birthplace Columbia, Penna.

16. (a) Informant Mrs Frances M Hazard
(b) Address Home for Incurables

17 (a) Burial (Burial, cremation, or removal) (b) Date filed 4-3-48
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tilghman & Sons
(b) Address Baltimore, Md.

19 Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-31-48 (Month, day, year)

21. I certify that death occurred on the date above stated, that I attended deceased from Feb 6th 1948 to March 31st 1948 and that I last saw deceased alive on March 31st 1948

Immediate cause of death: Bronchial Pneumonia — Duration 4 days

Due to

Due to

Other conditions Pernicious Anemia
Hypertension and Arteriosclerosis
(Conditions contributing but not related to cause given on line above)

Date of operation
Major findings of operation

If woman: Duration of pregnancy

PHYSICIAN
Enter the name to which birth should be changed within 6 months.

22. If death was due to external causes (Fill in the following)
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur while at work? (Yes or No)
(e) Nature of injury
(f) Signature
Address
Date signed

23.

DEATHS

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

DEATHS

Registered No.

PLEASE WRITE PLAINLY. USE (X) TO SHOW YES OR NO. Read full instructions carefully before filling out certificate. Punctuation: periods after letters to indicate abbreviations; dashes between words and figures. Spell out all words. Do not abbreviate.

1. PLACE OF DEATH
(a) Baltimore City (Print)
(b) Street address
(c) Hospital or institution

2. USUAL RESIDENCE OF DECEASED
(a) State
(b) County
(c) City or town
(d) Street No.
(e) Color or race
(f) Single, married, widowed or divorced
(g) Date of birth
(h) Age
(i) Birthplace
(j) Citizen of what country

3. (a) NAME OF DECEASED

4. (a) If married, widowed or divorced
(b) Name of husband or wife

5. Date of death

6. (a) Usual occupation
(b) Industry or business
(c) Name of employer
(d) Birthplace
(e) Father's name
(f) Birthplace
(g) Mother's maiden name
(h) Birthplace

7. (a) Informant
(b) Address

8. (a) Burial, cremation or removal
(b) Cemetery or crematory
Location
(c) Funeral director
(d) Address

9. Filed

MEDICAL CERTIFICATION

10. DATE OF DEATH

11. I saw the body of the deceased person named herein at

12. CAUSE OF DEATH

Duration

Contributory

Operation

Date of operation

Autopsy

13. If death was due to external causes (Fill in the following)
(a) Accident, suicide or homicide
(b) Date of occurrence
(c) Where did injury occur?
(d) Did injury occur while at work?

14. Signature

Address

Date signed

X

VS 150

66 1849

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 66 1849

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered with answer "unknown" where necessary, but no space should be left blank. Data is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address Calvert St
(c) Hospital or institution Mercy
(d) Length of stay in hospital or inst. yrs., mos. or days 22 days
(e) Length of stay in Baltimore yrs. mos., or days 50 yrs

2. USUAL RESIDENCE OF DECEASED
(a) Same
(b) City or town Baltimore
(c) Street No. 2234 Cedley Pl
(d) Citizen of foreign country? Yes or No?
If yes, name country

3. (a) FULL NAME John Hann (Hahn)
3 (b) If veteran, name war
3 (c) Social Security Account No. 212-01-8325 A

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife Elizabeth Hann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14 1872

8. AGE: Years 76 | Months 2 | Days 18 | If less than one day: hr | min

9. Birthplace N. J. (Town, county, and state)

10. Usual Occupation None Retired

11. Industry or business

FATHER
12. Name John Hann
13. Birthplace N. J.

MOTHER
14. Maiden Name Ellen Garrison
15. Birthplace N. Y.

16 (a) Informant wife
(b) Address 2234 Cedley St.

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof 4/5/48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location A. A. Co. Md.
William [illegible] Jr

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1948 at 8:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 21 1948 to April 2 1948, and that I last saw him alive on April 2 1948.

Immediate cause of death: Respiratory failure — Duration

Due to Hypertensive C-V disease

Due to Cerebro vascular accident

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)

Jos [illegible]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1850

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully verified and is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address 27 N Caroy St
(c) Hospital or institution Good Samaritan Hosp
(d) Length of stay in hospital or usual residence: yrs. mos. or days? Died
(e) Length of stay in Baltimore: yrs. mos. or days 60 y

2. USUAL RESIDENCE OF DECEASED
a. State Md. b. County
c. City or town Balto
(If outside city or town limits, write RURAL and give district)
d. Street No. 627 E. Balto St.
(If rural give location)
e. Citizen of foreign country? Yes or No
If yes, name country

3. (a) FULL NAME George R. Hoy

(b) If veterans, service war: No.

4. Sex M | 5. Color or race White | 6. (a) Single, married, widowed, or divorced? S-W-D

6. (b) Name of husband or wife

6. (c) If widow, give age years

7. Birth date of deceased: mo., day or yr. Abt 1860

8. AGE: Years 60 | Months | Days | If less than one day

9. Birthplace Maryland (State, country, and city)

10. Usual Occupation Fireman

11. Industry or business

12. Name Jos Hoover Hoyer

13. Birthplace

14. Maiden Name

15. Birthplace

16. Place Good Samaritan Hosp

17. Address 27 N Caroy St

18. (a) Balto (b) Date buried 2-5-18
(Cemetery, crematory, or vault) (month, day, year)

(c) Cemetery or crematory Maryland Park
Location Forest Park Md

19. (a) Funeral director Wm. A. Leary, Son & Co.

(b) Address 847 S. Paul St.

20. Date received 2-5-18 (c) Signature
(Date filed by registrar) Registrar

MEDICAL CERTIFICATION

21. DATE OF DEATH March 31 1918

22. I certify that death occurred on the date above stated; that I attended deceased from March 31 1918 to March 31 1918; and that I last saw h alive on March 31 1918

Immediate cause of death Senility

Due to Arteriosclerosis

Due to

Due to

Other Conditions

Duration

PHYSICIAN

Underline the cause to which death should be charged under these rules.

Date of operation

Major findings of operation

of autopsy

23. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur while at work or elsewhere? (Specify home, farm, or other)
(e) Nature of injury
25. Signature Libby McPherson
Address 27 North Caroy St

X.

2(18:1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1927

Registered No. 18:1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 603 [illegible]
(c) Hospital or institution

(d) Length of stay in hospital or home since onset of illness

(e) Length of stay in Baltimore since onset of illness

2. Usual residence of deceased

3. Color

4. Sex

5. Married, widowed, or divorced

6. Date of birth

7. Age

8. Occupation

9. Birthplace

10. Name of father

11. Birthplace of father

12. Maiden name of mother

13. Birthplace of mother

14. Informant

15. Filed

16. Burial, cremation, or removal

17. Undertaker

18. Address

19. Date of death

20. I hereby certify that I attended the deceased from [illegible] to [illegible] that I last saw the deceased alive on [illegible] and that death occurred, from the cause and on the date stated above, at [illegible] M.

Cause of death

Contributory (secondary)

Where was disease contracted, if not at place of death?

Duration of disease

Was disease epidemic?

Was operation performed?

Was autopsy performed?

Was death due to external causes (violence)?

Manner of injury

Where did injury occur?

Was injury accidental, suicidal, or homicidal?

Was injury received in industry?

Was injury received while deceased was engaged in any occupation for profit?

Name of physician

Address

Date signed

Weight at birth

Weight at death

Date of death

Name William A Simms

Age [illegible] years [illegible] months [illegible] days

Sex Male

Color White

Married

Occupation Laborer

Birthplace Maryland

Usual residence 603 [illegible] St

Date of birth [illegible] 1863

Age 63 years

Father's name [illegible]

Birthplace of father Maryland

Mother's maiden name [illegible]

Birthplace of mother Maryland

Informant [illegible]

Filed [illegible]

Burial [illegible]

Undertaker [illegible]

Address [illegible]

Date of death [illegible] 1927

I hereby certify that I attended the deceased from [illegible] to [illegible] that I last saw the deceased alive on [illegible] and that death occurred, from the cause and on the date stated above, at [illegible] M.

Cause of death [illegible]

Contributory (secondary) [illegible]

Duration of disease [illegible]

Was operation performed? [illegible]

Was autopsy performed? [illegible]

Was death due to external causes (violence)? [illegible]

Manner of injury [illegible]

Where did injury occur? [illegible]

Was injury accidental, suicidal, or homicidal? [illegible]

Was injury received in industry? [illegible]

Was injury received while deceased was engaged in any occupation for profit? [illegible]

Name of physician [illegible]

Address [illegible]

Date signed [illegible]

Weight at birth [illegible]

Weight at death [illegible]

Date of death [illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Usual address MANUMENT
(c) Hospital or institution
SINAI HOSP 17

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 / 25

2. USUAL RESIDENCE OF DECEASED
(a) State
(b) City or town
(If outside city or town limits write R.F.D. and give route)
(c) Street No. 230
(If rural, give location)
(d) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Mary B Skipper

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: FARMER V SR.

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) SEPT. 19, 1897

8. AGE: Years: 50 | Months: 5 | Days: 12 | If less than one day: hr. min.

9. Birthplace: RICHMOND, VA (Town, county, and state)

10. Usual Occupation: HOUSEWIFE

11. Industry or business

FATHER
12. Name: NOAH COLE
13. Birthplace: HALTO. CO., MD

MOTHER
14. Maiden Name: SARAH CORNELIUS
15. Birthplace: HALTO. MD.

16 (a) Informant: MR. NOAH H SKIPPER
(b) Address: 2605 CECIL AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/6/48 (month) (day) (year)
(c) Cemetery or crematory: ST. MARYS
Location: HAMPDEN - CITY

18 (a) Funeral director: WM J. TICKNER & SONS INC.
(b) Address: HALTO. MD.

19 (a) APR 3 - 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1948, at 7 AM PM

21. I certify that death occurred on the date above stated; that I attended deceased from 28 Mar 1948 to Apr 1 1948, and that I last saw her alive on apr 1 1948.

Immediate cause of death: Bleeding from esophagus — Duration: 2 hrs

Due to: esophageal varices — ?

Due to: Cirrhosis of the liver — 2 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Marion H. Dawson M. D.
Address: Sinai Hosp Date signed 4-2-48

VS 150

X

661853

GM. 38106

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

437

Registered No. 661853

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 S. Collins Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elmer E. Nicholson

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Amelia Nicholson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12 1889

8. AGE: Years	Months	Days	If less than one day
58	11	19	hr. min.

9. Birthplace MD.
(Town, county, and state)
10. Usual Occupation Insp. Wgts & Measures
11. Industry or business Balto City

MOTHER - FATHER

12. Name James E. Nicholson (D)
13. Birthplace MD.
14. Maiden Name Florence Dilcher (D)
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospital
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto, MD.

18 (a) Funeral director Wm. J. Tiefner & Son
(b) Address Balto, MD.

19 (c) APR 3 - 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-1- 1948, 6.35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-19-1944 to 4-1-1948, and that I last saw h im alive on 4-1-1948.

Immediate cause of death	Duration
Cerebrovascular accident c convulsions and coma	24 hrs
Due to Hemorrhage from ruptured vessel	
Due to Hypertensive Vascular disease.	7
Other Conditions Bronchopneumonia?	24 hrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed 4-1-48

VS 150

G61854

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 45B

APR 20 1948 Registered No. G61854

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 11 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3011 W North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Herbert H. Warner

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 717-07-7214

4. Sex	5. Color or race	6 (a) Single, (married), widowed, or divorced
Male	White	

6 (b) Name of husband or wife: Blanche M Warner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): Oct 28, 1874

8. AGE: Years	Months	Days	If less than one day
73	5	3	hr min

9. Birthplace: Baltimore, Md (Town, county, state or state)
10. Usual Occupation: Retired - Car Inspector
11. Industry or business: RR

FATHER
12. Name: John Warner
13. Birthplace: Frederick, Md

MOTHER
14. Maiden Name: Margaret Stiles
15. Birthplace: Germany

16 (a) Informant: Mrs Blanche M Warner (wife)
(b) Address: 3011 W North Ave

17 (a) To A. (Burial, cremation, or removal) (b) Date thereof 4/ (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) APR 3 - 1948 (Date rec'd by registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/1 1948, at 11 55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-27 1948 to 4/1 1948, and that I last saw him alive on 4/1 1948.

Immediate cause of death	Duration
Unknown	
Due to post operative	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 3/30/48
Major findings of operation: Carcinoma of Tongue
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: John F Brown M.D.
Address: 1000 Hoyt Date signed: 4/2

VS '51

X

661855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 661855

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N Carey St
(c) Hospital or institution
North Gamarda Hosp
(d) Length of stay in hospital or instit. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(d) Street No. 512 N Calhoun St
(e) Citizen of foreign country? Yes or No?
If yes, name country

3. (a) FULL NAME Mary Murray

(b) If veteran, name war (c) Social Security Account No.

4. Sex F | Color or race White | (c) Single, married, widowed, or divorced Widow

5. (a) Name of husband or wife Edward Murray
(b) If dead, give age

6. Birth date of deceased (mo., day, yr.) Sept 1 1877

7. AGE: Years 59 Months Days If less than one day

8. Birthplace West Va

9. Usual Occupation Domestic

10. Industry or business

11. Name Jasper Johnson

12. Birthplace Wash Twp W Va

13. Residence Wash Twp W Va

14. Informant James H Foster

15. Address 1520 Desmond Ave

16. Burial Date June 3 1937

17. Undertaker or undertaking establishment Wm Lefevre Sons

18. Filed June 3 1937 Registrar Mrs Julia K Wildgoose

19. (a) Date received by local registrar June 3 1937
(b) Registered number 661855

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1937

21. I certify that I attended the deceased from June 3 1937 to June 3 1937 and that I last saw h[illegible] alive on June 3 1937

Immediate cause of death
(a) Coronary Embolism
Due to
Due to
Other conditions Chronic Myocarditis

Duration

AUTOPSY

Contributing conditions but not related to cause given

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

If accident

22. If death was due to external causes (Fill in the following)
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(d) Did injury occur while at work, while engaged in military service, or while in civilian occupation

(e) Nature of injury

(f) Manner of injury

23. (a) Signature
(b) Address

24. Filed

25. Amended

26. Amended

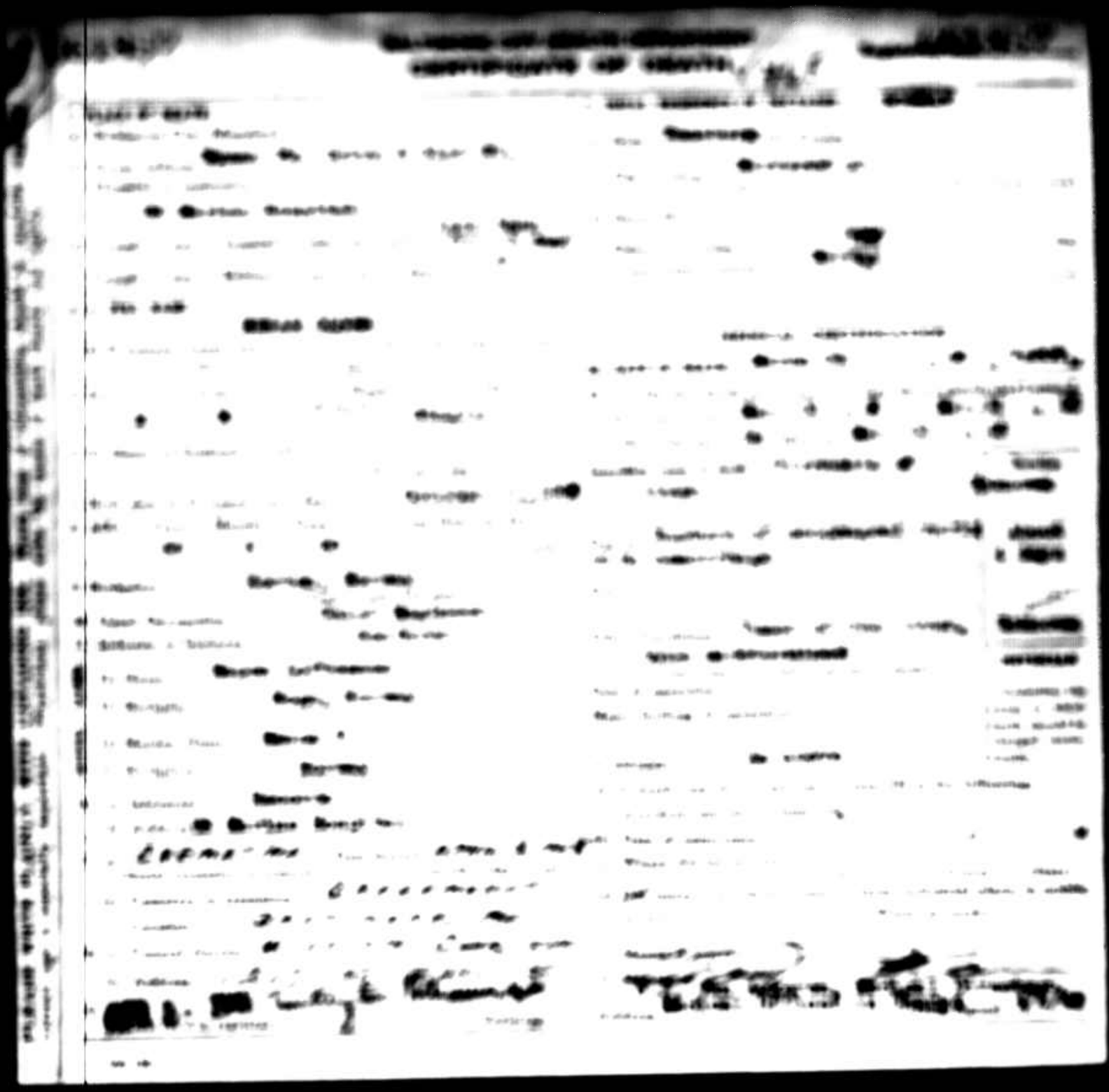
27. Amended

28. Amended

29. Amended

30. Amended

Please write plainly. Use ink. Do not use lead pencil. Many items of information should be carefully supplied for the use of the Census Bureau. Physicians: please write the cause of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30

Registered 1858

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 614 Division Street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or instn. (yrs., mos., or days) All
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) Ward Baltimore County
(b) City or town Baltimore (If outside city or county limits, write RURAL and give township)
(c) Street No. 719 N. Stricker St. (If rural give location)
(d) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Wallace

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/28/18 1896

8. AGE: Years 52 | Months 3 2 | Days 3 2 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation School Teacher

11. Industry or business

FATHER
12. Name William A. Jackson
13. Birthplace Onancock Va.

MOTHER
14. Maiden Name Margaret Henry
15. Birthplace Salisbury Md.

16 (a) Informant Mrs. Ophelia Kerr
(b) Address 172 N Carrollton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Chas. H. Hyland
(b) Address 1631 Druid Hill Ave.

19 (a) APR 3 - 1946 (b) (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/30 1946 at 8 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 3/30 1946 to 3/30 1946 and that I last saw h.er alive on 3/30 1946

Immediate cause of death Rupture of Thoracic aneurysm of aorta - Hemorrhage

Due to Generalized arterio-sclerosis

Due to

Other Conditions Nephrosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Rupture Thoracic aneurysm

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marcus W. Mare Sr.
Address Provident Hospital Date signed 4/3/46

X

661859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓183

661859 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Gilert Street
(c) Hospital or institution: City Morgue 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 N. Fulton Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Edward Hailstork

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-9542

MEDICAL CERTIFICATION

DATE OF DEATH 4-1-1948, at 9:30 A.M.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Hattie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 3, 1915

8. AGE: Years 32 | Months 7 | Days 29 | If less than one day hr. min.

9. Birthplace Norfolk, Va (town, county, and state)

10. Usual Occupation Crane operator

11. Industry or business

FATHER
12. Name Joseph B. Hailstock
13. Birthplace Norfolk, Va

MOTHER
14. Maiden Name Mary Woods
15. Birthplace Middlesex Co. Va

16 (a) Informant Mrs. Mary Johnson
(b) Address 1128 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/1948 (month) (day) (year)
(c) Cemetery or crematory National Cemetery
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) APR 3 - 1948 (Date rec'd by registrar) (b) Livingston Williams, M.D.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Found 4/1/48 6:30 A.M.
(b) Where did injury occur? Foot of Pier #10, Light Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public (Harbor) While at work? NS
Means of injury Found Drowned

23. Signature Medical Examiner. M.D.
Date signed 4/1/48

VS 151

X 473

661860 GM. 118614

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 45F

Registered No. 661860

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Date of death is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 66½ Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1232 Patapsco ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** John Hübschman (Hiibschman)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife ~~Virginia~~ (Regina)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21 -1880

8. AGE: Years	Months	Days	If less than one day
67 Yrs.	11	11	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Hubschman
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Germany

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-5-1948 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Md

18 (a) Funeral director Flanagan & Flanagan
(b) Address 1426 Light St

19 (a) APR 3 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 2 - 1948, at 9.08 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4 - 1 - 1948 to 4 - 2 - 1948 and that I last saw him alive on 4 - 2 - 1948.

Immediate cause of death Cpd the pharynx — Duration

Due to

Due to

Other Conditions Malnutrition; (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Of autopsy Cpd Court — yrs

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jordan Court M. D.
Address Balt City Hosp. Date signed 4-2-48

VS 180

X

661861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 661861

St. 95211

PLEASE WRITE PLAINLY. WITH EXCEPTIONS (SEE) Entry items of information should be carefully supplied correct age is especially important. Physicians, please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution
Baltimore City Hospitals
(d) Length of stay in hospital or instn. (yrs., mos., or days) 2 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(d) Street No. 2810 Edgewood
(e) Citizen of foreign country? Yes or No?
If yes, name country

3. (a) FULL NAME James J. Manning

(b) If veteran, name war
(c) Social Security Account No.

4. Sex M | 5. Color or race W | 6. (a) Single, married, widowed, or divorced Divorced

(b) Name of husband or wife

(c) If child, give age years

7. Birth date of deceased (Mo., day, yr.) Aug. 3 - 1889

8. AGE: Years 49 | Months 6 | Days 27 | If less than one day: hrs. min.

9. Birthplace MD.
(State, county, and city)

10. Usual Occupation
11. Industry or business

12. (a) Name Richard
(b) Birthplace MD.

13. (a) Maiden Name Lilly Stanton
(b) Birthplace MD.

14. (a) Informant Baltimore Balto. City Hospitals
(b) Address (Give street address or location)

15. (a) Burial, cremation or removal James
(b) Date
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

16. (a) Funeral director Philip Ford & Son
(b) Address 2101 E. Monument St.

17. Filed APR 3 - 1948 (Date must be filed within 5 days of death) Registrar Baltimore

MEDICAL CERTIFICATION

18. DATE OF DEATH 4 - 1 - 48 at 1:07 P.M.

19. I certify that death occurred on the date above stated, that I attended deceased from 3-1-48 to 4-1-48, and that I last saw h 28 days ago. 4 - 1 - 48

Immediate cause of death Pulmonary Tuberculosis

Due to

Due to

Other Conditions Chronic Cholecystitis

Duration: P

Date of operation

Major findings of operation

20. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town; County; State)
(d) Did injury occur while deceased was at work, industrial plant, in public place? Yes or No?
(e) Nature of injury
21. Signature Lawrence Lee Jr.
Address Baltimore City Hospitals

PHYSICIAN

If certificate was made to which death should be charged, write death

VS 10c

GG1862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. GG1862

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered, even if necessary data is not known or is doubtful, the word "unknown" or the correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
(a) Baltimore City Maryland
(b) Street address
(c) Hospital or institution Sinai Hospital
(d) Length of stay in hospital or inst. yrs. mos. or days 1 day
(e) Length of stay in Baltimore yrs. mos. or days Lifetime

2. USUAL RESIDENCE OF DECEASED
a. State Md. b. County
c. City Baltimore
d. Street No. Ingram Hall Apt.
e. Citizen of foreign country? No Yes or No
If yes, name country

3. (a) FULL NAME David Stiefel (David Stiefel)
(b) If veteran, name war (c) Social Security Account No.

MEDICAL CERTIFICATION

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Carline R. Stiefel (c) If alive, give age Years
7. Birth date of deceased mo. day yr. Sept. 27 1871
8. AGE: Years 76 Months 6 Days 5 If less than one day: hr. min.
9. Birthplace Baltimore, Md. (Town, county, state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Julius Stiefel,
13. Birthplace Germany.

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16. (a) Informant Mrs. Carline R. Stiefel,
(b) Address Ingram Hall Apt

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/48 (month) (day) (year)
(c) Cemetery Orchard Ridge
Location Balto. Md.

18. (a) Funeral director Harid Sonnheim & Son
(b) Address 1902 Eutaw Place

19. (a) APR 3 - 1948 (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

20. DATE OF DEATH 4/1 1948 at 11:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1948 to 4/1 1948 and that I last saw h alive on 4/1 1948

Immediate cause of death Pulmonary Edema

Due to Arteriosclerotic Cardiac Degeneration

Due to Cystectomy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 2 hrs

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
a. Accident, suicide or homicide
b. Date of occurrence at M
c. Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, or public place? (While at work)
d. Means of injury

23. Signature Leonard Wilson
Address 5 7 1, park. Hgts Ave Date signed 4/1/48

X

VS 180

G61863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G61863

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1623 E. Preston St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town.)

(d) Street No. 1623 E Preston St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Luella Green

3 (b) If veteran, name war

3 (c) Social Security Account No

4. Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Walter

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr: Aug. 2 19[illegible]

8. AGE: Years 45 | Months 7 | Days 29 | If less than one day: hr. min

9. Birthplace: Aberdeen Md (Town, county, and state)

10. Usual Occupation: Domestic

11. Industry or business

MOTHER / FATHER

12. Name: Shaw Henry Green

13. Birthplace: Md

14. Maiden Name: Alice Hoke

15. Birthplace: Md

16 (a) Informant: Alice Jennings

(b) Address: 1623 E Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 4 48 (month) (day) (year)

(c) Cemetery or crematory: Arbutus Memorial Park

Location: Arbutus Md.

18 (a) Funeral director: Mrs Rotta Elliott Dept

(b) Address: 1129 N. Carrollton St

19 (a) APR 3 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1948 at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1947 to March 31 1948 and that I last saw h alive on March 31 1948.

Immediate cause of death: Metastatic Carcinoma of 4-5 Lumbar Vertebra

Due to [redacted]

Due to Metastasis following amputation of Breast (R).

Other Conditions: Mitral Insufficiency.

(Include pregnancy within 3 months of death)

Duration
Aug 1947 March 1948
2 yr.
2 yr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

Date of operation: None

Major findings of operation:

of autopsy: No

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) (While at work)

(e) Means of injury

23. Signature: Ralph L Young

Address: 1429 E Monument Date signed: 4/1/48

VS 1-80

661864 SC-48-06848 BALTIMORE CITY HEALTH DEPARTMENT 661864
CERTIFICATE OF DEATH 159 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caltons St.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hours
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(c) Street No. 437 N. Glover st
(If rural give location)
(d) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sharon Lee Marchiano
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex female
5. Color or race white
6. (a) Single, married, widowed, or divorced —
6. (b) Name of husband or wife
6. (c) If alive, give age years
7. Birth date of deceased: mo. day yr. March 29, 1918
8. AGE: Years Months Days If less than one day: hrs. or min.
2 19
9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Grocer boy
11. Industry or business

FATHER
12. Name Frank Anthony Marchiano
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Dorothy Frances Friend
15. Birthplace Baltimore, Md

16. (a) Informant Franklin Square Hosp
(b) Address
17. (a) Burial (b) Date closed 4/3-48
(Burial, cremation, or removal)
(c) Cemetery Holy Redeemer
Location Holy Rd. Baltimore Md
18. (a) Funeral director Frank DeBaltasi
(b) Address 524 Hanover St. Baltimore, Md.
19. (a) Apr 3 - 1948
(Date received by registrar) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH April 1 19 48 at 5:20 PM
21. I certify that death occurred on the date above stated, that I attended deceased from 3-29 19 48 to 4-1 19 48 and that I last saw h.e.r alive on 4-1 19 48
Immediate cause of death
Pulmonary Failure
Due to Pneumonia
Due to
Other Conditions
Duration
(Including antepartum conditions within 3 months of death)
Date of operation
Major findings of operation
If autopsy
PHYSICIAN
Underline the cause to which death should be charged under rules.
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur while at work?
(Specify type of place)
(e) Manner of injury
(f) Nature of injury Pleurisy
Address 524 N. Arlington Ave. Date signed 4-1-48
M. D.

PH 220

(66)8965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

66)8965
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2223 W Saratoga St
(c) Hospital or institution
(d) Length of stay in hospital or instn. (yrs., mos. or days) 7
(e) Length of stay in Baltimore (yrs. mos. or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) Street
(b) Number
(c) City or town Baltimore
(d) Street No. 2223 W. Saratoga St
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Minnie Louise Nicholson
(b) If veteran, name war None
(c) Social Security Account No. None

4. Sex Female
5. Color or race White
6. (a) Single, married, widowed, or divorced Widow
(b) Name of husband or wife Charles Nicholson
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6 1872
8. AGE: Years 65 Months 6 Days 26 If less than one day, hrs. or min.
9. Birthplace Baltimore, Maryland (City, county and State or foreign country)
10. Usual Occupation housework
11. Industry or business None

FATHER
12. Name John Hubley
13. Birthplace Maryland

MOTHER
14. Maiden Name Maggie Tettman
15. Birthplace Maryland

16. (a) Informant Louis Nicholson
(b) Address 2100 Park Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-5-48 (Month) (day) (year)
(c) Cemetery or crematory Druid Hill Cemetery
Location Baltimore, Maryland

18. (a) Funeral director Geo. J. Schmidt
(b) Address 2101 Woodbrook Avenue

19. (a) (Date received by registrar) Huntington Hillsboro

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1948 at 4:50 P.M.
21. I certify that death occurred on the date above stated, that I attended deceased from Jan 1 1947 to April 5 1948, and that I last saw h. alive on April 5 1948
Immediate cause of death Cerebral Thrombosis
Due to Arteriosclerosis
Due to
Other Conditions Diabetes Mellitus
(Indicate pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

Duration 2 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature C. J. Peterson Jr.
Address 1935 W Baltimore St Date signed April 6 1948

APR 8 1948
VS 189

93D

661866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

661866 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1214 Eutaw Place
(c) Hospital or institution: Baltimore Eye, Ear & Throat Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Florida (b) County Duval
(c) City or town Jacksonville (?)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1150 Homesdale Road.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Mrs Rea Jarchower

3 (b) If veteran, name war: No

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harry Jarchower (Unknown → 6 (c) If alive, give age ____ years)

7. Birth date of deceased (mo., day, yr.) 9 Jan 1897

8. AGE: Years 51 | Months 2 | Days 25 | If less than one day: ____ hr. ____ min.

9. Birthplace Brooklyn, N.Y (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Housewife

FATHER
12. Name Harris Miller
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah Zimmerman
15. Birthplace Russia

16 (a) Informant Rea H Jarchower
(b) Address 1150 Homesdale Rd, Jacksonville Fla.

17 (a) Removal (burial, cremation, or removal) (b) Date thereof 4-3-48 (month) (day) (year)
(c) Cemetery or crematory Jacksonville Fla
Location

18 (a) Funeral director Jacob Lewis Inc.
(b) Address 2120 Eutaw Place

APR 4 - 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 April 1948 at 12:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 30 March 1948 to 3 April 1948 and that I last saw her alive on 3 April 1948.

Immediate cause of death Coughing fainting during pentothal anesthesia — Duration

Due to

Due to

Other Conditions Hypertension, cataracts both eyes
(Include pregnancy within 3 months of death)

a. Date of operation 3 April 48

Major findings of operation: Cataracts both eyes

of autopsy: - Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph C. Bruenbach M.D.

Address 1214 Eutaw Place Date signed 3 April 48

VS 3

G61867

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G61867
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 645 W. Lombard
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Henry Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Divorced

6 (b) Name of husband or wife Ida M Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-13-1872

8. AGE: Years	Months	Days	If less than one day
75	6	20	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Wm Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Wm R Smith
(b) Address 645 W. Lombard St Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-5-48 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Ellicott City Md

18 (a) Funeral director J. C. Higinbothom
(b) Address Ellicott City Md

19 (a) 1948 APR 4 (b) Registrar Huntington Williams, M.D.

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MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1948, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/25/48 19 . to 4/1 2 1948, and that I last saw h alive on 4/1 2 1948.

Immediate cause of death	Duration
Myocardiosclerosis	4 years
Due to Hypertension	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm O Rouse
Address 201 N Edmondson Ave Date signed 4/3/48

G61868

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 163B

✓ G61868 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3614 Springdale (If general give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Janet Jeannette Briskeman

3 (b) If veteran, name war WORLD WAR I

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years 49 | Months | Days | If less than one day: hr. min.

9. Birthplace BALTO (Town, county, and state)

10. Usual Occupation CLERK, U.S. COAST GUARD

11. Industry or business

FATHER
12. Name NATHAN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name FANNIE
15. Birthplace RUSSIA

16 (a) Informant BESSIE B. GOODMAN
(b) Address 1912 N. BROADWAY AVE. NEW YORK

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-4-48 (Month, day, year)
(c) Cemetery or crematory Greenmount
Location Belair Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1908 Eutaw Pl.

APR 4 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1948, at 8 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Phenobarbital poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-1-48 at ? A.M.
(b) Where did injury occur 3614 Springdale
(c) Did injury occur at home, on farm, industrial place, in public place) Home (While at work) no
(d) Means of injury Barbiturate Poisoning

23. Signature Chas. A. Reyburn M.D.

Date signed 4-2-48

X

661869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

661869

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address MONUMENT ST
(c) Hospital or institution SINAI HOSP
(d) Length of stay in hospital or institution, years, months or days
(e) Length of stay in Baltimore, years, months or days

I. USUAL RESIDENCE OF DECEASED
a. State MD b. County
c. City or town BALTO
d. Street No. 1511 N SPRING AVE
e. Inside city limits (Yes or No)
f. Citizen of foreign country? (Yes or No) If yes, name country

2. (a) FULL NAME ANNIE KAINETT
(b) If veteran, name war — (c) Social Security number —
3. Sex — 4. (a) Color or race — (b) Single, married, widowed or divorced WIDOW
5. (a) Name of husband or wife —
(b) If alive, give age — If dead, date of death —
6. Birth date of deceased, year, month, day —
7. AGE Years 78 Months — Days — If less than one day, hours or minutes
8. Birthplace POLAND
9. Usual Occupation —
10. Industry or business —
11. Name —
12. Birthplace —
13. Married Name —
14. Birthplace —
15. a. Informant —
b. Address —
16. a. Burial, cremation or removal —
b. Cemetery or crematory —
Location —
17. a. Undertaker —
b. Address —
18. Date of receipt —

MEDICAL CERTIFICATION
19. DATE OF DEATH —
(a) I certify that death occurred on the date above stated, from the cause(s) and on the date(s) stated below.
(b) I last attended deceased from — to —
and last saw deceased alive on —
Immediate cause —
Antecedent causes —
Contributory causes —
Other conditions —
Operation —
Date of operation —
Major findings of operation —
If autopsy —
(c) I viewed body after death on —
(d) Date of operation —
(e) Where did injury occur? —
(f) This injury occurred while at work, not while at work, while in public conveyance, while in private conveyance, in public place, in home, not indicated whether in public or private place
(g) Manner of injury —
(h) Source of information —
(i) Was case referred to Coroner? —
Was autopsy performed? —
Were findings considered in determining cause of death? —
20. Date signed —
21. Address —

Duration

PHYSICIAN

Certification that name is correct and death should be recorded under this name

PLEASE WRITE PLAINLY WITH INDELIBLE INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6 66870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

66152

1. PLACE OF DEATH

(a) Baltimore City Municipal

(b) Usual residence Edmondson & Bruce

(c) Hospital or institution Dunbar Hosp. Inc.

(d) Length of stay in hospital or institution, years, months or days 3 days

(e) Length of stay in Baltimore, years, months or days 6 yrs

2. USUAL RESIDENCE OF DECEASED

(a) Residence No 1

(b) Street and number [illegible]

(c) Length of stay in place for which reported, years, months, or days, and give usual residence

(d) Citizen of what country? Yes or No

If yes, name country

3. (a) FULL NAME Edna D Beer

(b) If veteran, name war

(c) Social Security number

4. Sex F

5. (a) Color or race W

(b) Married, never married, widowed or divorced

6. (a) Name of husband or wife

(b) If widow, give age years

7. Death date of deceased was the [illegible] day

Month Nov Year 1939 Hour [illegible] a.m. or p.m.

8. Age 60 Years 0 Months 0 Days

9. Birthplace Md

City, county and state

10. Usual Occupation Domestic

11. Industry or business

12. Name Robert Beer

13. Birthplace Germany

14. Maiden Name [illegible]

15. Birthplace [illegible]

16. (a) Informant Eugene Geo. J. Ingalsbe

(b) Address 1 [illegible]

17. (a) Burial

(b) Date buried Nov 24 39

(c) Cemetery or crematory [illegible]

Location Baltimore, Md.

18. (a) Funeral director H. G. Wagner & Son

(b) Address 805 W. Calhoun St.

Huntington, West Virginia

19. (a) Filed by registrar

(b) Registered

WHERE AND WHEN DEATH OCCURRED

20. Date of death Nov 21 1939

21. I certify that I attended the deceased from [illegible] to the date above stated, and that death occurred on the date stated above, at [illegible] m.

Cause

Due to Coronary Thrombosis

Due to Hypertension 2 yrs

Other conditions

Date of operation

Major findings of operation

PHYSICIAN

I certify that the cause to which death should be assigned and the facts stated are correct to the best of my knowledge and belief.

22. If death was due to external causes, fill in the following

(a) Accident, suicide or homicide

(b) Date of occurrence at M

(c) Where did injury occur? City or town County State

(d) Did injury occur while at work, while in private home, in public place? Specify type of place

(e) Manner of injury

(f) Nature of injury

23. Signature Edith Taylor

Address Edmondson & Bruce Date signed 11/24/39

X

661871

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH (95)

661871
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
a. Baltimore City Maryland
b. Street address 208 S Madeira St
c. Hospital or institution

d. Length of stay in hospital or instit. yrs. mos. or days
e. Length of stay in Baltimore yrs. mos. or days

2. USUAL RESIDENCE OF DECEASED
a. State Md. b. County
c. City or town Baltimore
(If outside city limits, write RURAL and give town)
d. Street No. 208 S Madeira St
(If rural, give location)
e. Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME George W. Kopec
(b) If veteran, name war
(c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
(b) Name of husband or wife: Josephine Kopec
6. If alive, give age years

7. Birth date of deceased mo. day yr
8. AGE: Years 64 | Months | Days | If less than one day hr min

9. Birthplace Poland (town, county and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Unk
13. Birthplace Poland

MOTHER
14. Maiden Name Unk
15. Birthplace Poland

16. (a) Informant Josephine Kopec
(b) Address 208 S Madeira St

17. (a) Buried (Burial, cremation, or removal) (b) Date thereof 4-5-48 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore

18. (a) Funeral director Fred W Ozarowski
(b) Address 1930 Eastern Ave

19. (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1948 - 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1947 to April 2 1948 and that I last saw h. alive on April 2 1948

Immediate cause of death
Myocardial Insufficiency — Duration 3 days
Due to Arteriosclerosis — 10 yrs.
Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John V. Zagrodnik M. D.
Address 1802 Eastern Ave Date signed 4-3-48

APR 6 1948
VS 150
Huntington Williams, M.D.

X

G61872

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G61872 Registered No. 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5916 Kavon Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5916 Kavon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Adelina Donatelli

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Anthony Donatelli
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20 1876

8. AGE: Years	Months	Days	If less than one day
72	1	12	hr. min.

9. Birthplace Ateleta Aquila Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Costantino Rossi
13. Birthplace Italy

MOTHER
14. Maiden Name Concetta Donatelli
15. Birthplace Italy

16 (a) Informant Anthony Donatelli (Husband)
(b) Address 5916 Kavon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) APR 6 1948 (Date received by registrar) (b) Tunstun Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1948, at 7:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-27 1948 to 4-5 1948 and that I last saw h[illegible] alive on 4-5 1948.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerosis & Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rachel Donatelli
Address 5916 Kavon Ave Date signed 4-6-48 M. D.

C61873

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

Registered No. C61873

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2128 Mt.MollySt.,
(c) Hospital or institution: 15-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2128 Mt.Holly St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Flannery

3 (b) If veteran, name war: --

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Edward Flannery
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 88 ? | Months | Days | If less than one day hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Patriek Nallon
13. Birthplace Ireland

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Mrs. James J. Kane
(b) Address 2128 Mt.Holly St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-5-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

Date rec'd (by registrar) APR 4 - 1948 Huntington Williams M.D.

APR 5 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1948 at 12 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to Apr 2 1948 and that I last saw h alive on Apr 2/48 19

Immediate cause of death: (a) Cerebral hemorrhage — Duration 2 days
Due to Advanced arterio-sclerosis
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter Dubbaff M. D.
Address 2220 Barron Blvd Date signed Apr 2/48

G61874

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

X G61874
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1111 Parkmont Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 wks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Wicomico
(c) City or town Salisbury (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Granville Fairfield Taylor

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Annie Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/17/79

8. AGE: Years	Months	Days	If less than one day
68	7	17	hr. min.

9. Birthplace Salisbury, Md. (Town, county, and state)
10. Usual Occupation Brick layer
11. Industry or business

FATHER
12. Name Julius Taylor
13. Birthplace Md.

MOTHER
14. Maiden Name Aurilo Taylor
15. Birthplace Md.

16 (a) Informant Annie Taylor (wife)
(b) Address 1111 Parkmont Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/48 (month) (day) (year)
(c) Cemetery or crematory Memorial Park
Location Salisbury

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 S. Wolfe Street

19 APR 4 - 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1948, at 2:08 A. M

21. I certify that death occurred on the date above-stated; that I attended deceased from March 1948 to April 5 1948, and that I last saw h in alive on April 5, 1948.

Immediate cause of death: Intestinal Obstruction
Due to Peritonitis
Due to
Other Conditions: Urinary Retention

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
5 days
5 years
5 years ?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature
Address 4200 Philadelphia Road Date signed April 6, 1948

VS 189

1172

61875

Blake

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 133a

Registered No. 61875

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1501 N. Eden St.

(c) Hospital or institution: 4-9

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (Or foreign country) (b) County

(c) City or town Baltimore (If outside city or town limits, write R.F.D. and give No.)

(d) Street No. 1501 N. Eden St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Jennie Cecelia Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female 5. Color or race Colored 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Elder Frank S. Johnson 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1891

8. AGE: Years 56 Months 6 Days 6 If less than one day hr. min.

9. Birthplace Montgomery Co. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name David Matthews

13. Birthplace Montgomery Co. Md.

MOTHER 14. Maiden Name Nannie Short

15. Birthplace Charles Co. Md.

16 (a) Informant Elder Frank S. Johnson

(b) Address 1501 N. Eden St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5, 1948 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk.

Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George A. Stafford

(b) Address 1691 Druid Hill Ave.

19 (a) Date received APR 5 1948 (b) Registrar's signature Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-31-1948, at 1:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/25-48 to 3/31/48.

And that I last saw h alive on 3/31 1948.

Immediate cause of death

Duration

Due to Hepatitis Cirrhosis and Pyelonephritis 5 mos.

Due to Peritonitis and Sepsis 5 days

Due to Intestinal Obstruction —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?) (Specify type of place)

(e) Means of injury

23. Signature J. H. Blake M. D.

Address 1803 N. Carolina Signed 4/3/48

VS 150

G61876 Jackson

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 52B

Registered No. G61876

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary D. Lancey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5 Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1881

8. AGE: Years 67 | Months 9 | Days 5 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business

FATHER
12. Name J. Edward Lancey
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Deborah A. Taylor
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. J. Wallis Lancey
(b) Address 1701 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Mrs. George A. Holland
(b) Address 1631 Druid Hill Ave. Huntington Williams, M.D.

19 (a) [illegible] (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/2 1948 at 3:4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5 1948 to 4/2 1948.
and that I last saw h[illegible] alive on 4/2 1948.

Immediate cause of death: Carcinoma of Bladder, metastasis — Duration: 4 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature H. L. Jackson M.D.
Address 680 N. Carey St. Date signed 4/3/48

VS 150

G61877

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 467

G61877
Registered No.

PLEASE WRITE LEGIBLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Dr. & 31st St.,
(c) Hospital or institution: U. S. Marine Hospital 9-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 938 Homestead St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME George Drum Lippincott

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mabel Cady Lippincott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1882

8. AGE: Years	Months	Days	If less than one day
66	1	9	hr. min

9. Birthplace Titusville, Pa. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Lippincott
13. Birthplace Pa.

MOTHER
14. Maiden Name Rebecca Reeves
15. Birthplace Pa.

16 (a) Informant: Hospital Records
(b) Address above

17 (a) Apr 7/48 (Burial, cremation, or removal) (b) Date thereof Apr 6/48 (month) (day) (year)
(c) Cemetery or crematory Location Washington D.C. Fort Mc Henry Baltimore Md.

18 (a) Funeral director
(b) Address 81 Huntington Philippines, Md

19 (a) APR 5 1948 (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 4 1948, at 3:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 18 1948 to Apr 4 1948, and that I last saw him alive on Apr 4 1948.

Immediate cause of death Carcinoma of rectum with pelvic extension and metastasis to peraoritic — Duration: 2y?
Due to lymph nodes and lungs.
Due to
Other Conditions Bilateral hydronephrosis and hydroureter — Duration: 6m?
(Include pregnancy within 3 months of death)
Date of operation Dec. 4, 1946
Major findings of operation: Carcinoma of rectum
of autopsy: Carcinoma of rectum.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Andrew J. McSweeney M.D.
Address Marine Hospital Date signed 4/4/48 (M D)

Andrew J. McSweeney

CG1878

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 132

Registered 61878

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 E. Lafayette Ave.
(c) Hospital or institution: home 8-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 E. Lafayette Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carlotta Gentry Kreis

3 (b) If veteran, name war: no
3 (c) Social Security Account No. -

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: George F.
6 (c) If alive, give age: years

7. Birth date of deceased: mo., day, yr. Aug. 24, 1877

8. AGE: Years 70 | Months 6 | Days 9 | If less than one day: hr min

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business -

FATHER
12. Name: Hayden Gentry
13. Birthplace

MOTHER
14. Maiden Name: McElroy
15. Birthplace

16 (a) Informant: George F. Kreis
(b) Address: 1918 E. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 6- (month) (day) (year)
(c) Cemetery or crematory: Cemetery
Location: New Cathedral

18 (a) Funeral director: Wm. Cook, Inc.
(b) Address: 1217 St. Paul Street

19 (a) APR 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 193

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 19 48 at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 19 1937 to Apr 2 1948.
and that I last saw S alive on 9

Immediate cause of death: Nephritis — Duration: 11 mos.
Due to
Due to
Other Conditions: Arthritis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Carol Fisher
Address: 1820 N. Broadway Date signed 4/3/48 M.D.

X

G61879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

463

Registered No. G61879

TYPEWRITE WHERE POSSIBLE, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland 27-20

(b) Street address Linden & Madison

(c) Hospital or institution: Maryland Genl Hospital

(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 10

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 619 Lincoln Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Martha Hooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 10-1878

8. AGE: Years	Months	Days	If less than one day
69	6	23	hr. min.

9. Birthplace Baltimore - Md (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

MOTHER / FATHER

12. Name George Truett

13. Birthplace Md

14. Maiden Name Ida Carr

15. Birthplace Md

16 (a) Informant (Son) James Hooper

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/48 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore Md

18 (a) Funeral director William Cook Inc

(b) Address 17 to 23 St Paul St

19 (a) APR 5 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/3 1948, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24 1948 to 4/3 1948 and that I last saw her alive on 4/3 1948.

Immediate cause of death: General Circulatory Collapse

Due to senility and Postoperative shock

Due to

Other Conditions Scirrhous Carcinoma of Stomach

(Include pregnancy within 3 months of death)

Date of operation 3/24/48

Major findings of operation: Carcinoma of Stomach

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John E Mullin M.D.

Address Kernan's Genl Hosp Date signed 4/5/48

VS 150

G61880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G61830

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address. 3320 W Calvert 28-1

(c) Hospital or institution: Union Memorial Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 4703 Groveland Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Gotlieb Wotthlie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Estella Wotthlie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 11 1881

8. AGE: Years	Months	Days	If less than one day: hr.	min.
66	4	23		

9. Birthplace GRAFTON, West Va (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER — 12. Name	Gottlieb Wotthlie
FATHER — 13. Birthplace	Smyrna Germany
MOTHER — 14. Maiden Name	Elizabeth Cooney
MOTHER — 15. Birthplace	Cumberland Md
16 (a) Informant	Richard H Wotthlie
(b) Address	4704 Groveland Ave
17 (a) Burial (Burial, cremation, or removal)	(b) Date thereof 4/7/48
(c) Cemetery or crematory	Green Mount
Location	Baltimore Md
18 (a) Funeral director	Wilhelm & Son
(b) Address	1219 W Fayette St
19 (a) Filed (Date received by Registrar) APR 5 1948	(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1948, at 9 25 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 3 1948, to April 4 1948, and that I last saw him alive on April 4 1948.

Immediate cause of death	Duration
Coronary occlusion	12 hrs.
a Myocardial Infarction	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature A. Wade Alford

Address Union Memorial Hosp Date signed 4/4/48 (M) (D)

VS 199

X

G61881

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 194a

Registered No. G61881

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & 33rd Sts. 9-6

(c) Hospital or institution Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore, Md. (If outside city or town limits, write "R.D." and give town)

(d) Street No. 1623 East 33rd St. (If no street address, give location)

(e) Citizen of foreign country? (Yes or No) No

If yes, name country

3 (a) FULL NAME Mrs. Alma May Robbins

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	

6 (b) Name of husband or wife William A. Robbins

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) April 2, 1882

8. AGE: Years	Months	Days	If less than one day: hr.	min.
66	0	2		

9. Birthplace James City Co., Va. (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name James H. Jester

13. Birthplace Va.

14. Maiden Name Miss Malone

15. Birthplace Va.

16 (a) Informant Husband — Mr. W. A. Robbins

(b) Address same

17 (a) Final (Burial, cremation, removal) (b) Date thereof 4-7-48 (month, day, year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Md.

18 (a) Funeral director Wilson & Son

(b) Address 1217 E. Fayette St.

19 (a) Filed APR 5 1948 (b) Registrar Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1948, at 3:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1948, to April 4 1948, and that I last saw her alive on April 4 1948

Immediate cause of death	Duration
Myocardial Rupture	seconds
Due to Myocardial Infarction	12 hrs
Due to Coronary Occlusion	12 hrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following

a Accident, suicide, or homicide

b Date of occurrence at M

c Where did injury occur? (City or town) (County) (State)

d Did injury occur about home, on farm, industrial place, in public place? While at work?

e Means of injury

23. Signature Mortimer Lee Williams

Address Union Memorial Hospital Date signed 4/4/48

VS 151

G61882 48-05973 AB-118159

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

Registered No. G61882

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-1 3days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 S. Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Cooper

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Col	Single

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14-1948

8. AGE: Years	Months	Days	If less than one day: hr.	min
		3		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Cooper
13. Birthplace S.C.

MOTHER
14. Maiden Name Doris Johnson
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 3-18-48 (month) (day) (year)
(c) ~~Cemetery~~ or crematory Balto. City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) APR 5 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17- 1948, at 8.25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14- 1948 to 3-17- 1948, and that I last saw her alive on 3-17- 1948.

Immediate cause of death	Duration
Prematurity	4 days
Due to	
Due to	
Other Conditions Aspiration	1 hr.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Prematurity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Julian P. Griffini M.D.
Address Balt City Hosp. Date signed 18 Mar 48

VS 150

61883 BC = 48-1140

JL - 118184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No. 61883

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave. 5-1

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1200 Canal Ct. Apt. A2 (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Jackson -Lavonia

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1948

8. AGE: Years	Months	Days	If less than one day
		1	hr min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name John Jackson

13. Birthplace Md.

MOTHER

14. Maiden Name Lavonia Briggs

15. Birthplace Md.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 3-18-48 (month) (day) (year) 9 a.m.

(c) [redacted] or crematory Balto. City Hospitals

Location 4940 Eastern Ave.

18 (a) Funeral director

(b) Address

19 (a) APR 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1948, at 10.09 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1948, to March 16 1948, and that I last saw her alive on March 16 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to	
Due to Prematurity	1 day
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Gross, plus Histologic

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?

(e) Means of injury

23. Signature Julian P. Griffin M D

Address Balto City Hosp Date signed 18 Mar '48

VS 180

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BCc 48-06818

G61884

JL - 118445

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

Registered No. G61884

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave. 18-2

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2days

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 334 N. Carrellton Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Schefield - Janie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1948

8. AGE: Years	Months	Days	If less than one day
		2	hr. min

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Fortune Schefield

13. Birthplace Md.

MOTHER

14. Maiden Name Janie Harper

15. Birthplace S. C.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof March 30-1948 (month) (day) (year)

(c) Cemetery or crematory Baltimore City Hospital

Location 4940 Eastern Avenue

18 (a) Funeral director

(b) Address

19 (a) APR 5 - 1948 (Date rec'd by registrar) (b) Huntington [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1948, at 8PM M

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1948 to March 27 1948. and that I last saw h im alive on March 27 19

I. Immediate cause of death Prematurity — Duration 2 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Prematurity

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature Hart Becker

Address Balto City Hosp Date signed 3/30/48 D

X

VS 150

G61885 (1)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 83a

Registered No. G61885

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 705 S. Bauldin St
(c) Hospital or institution: 26-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimar R. (If outside city or town limits, write RURAL and give town)
(d) Street No. 705 S Bauldin St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Kathryn L. Bien

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Geo L. Bien
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 24 18[illegible]

8. AGE: Years	Months	Days	If less than one day
70	-	8	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business At home

FATHER
12. Name Michael Warmuth
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Rohleder
15. Birthplace Germany

16 (a) Informant Mrs Myrtle Flesch
(b) Address 705 S Bauldin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5, (month) (day) (year)
(c) Cemetery or crematory St L E V Cemetery
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2005 Orleans St

19 (a) APR 5 - 1948 (b) [illegible]
Filed rec'd by registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. **DATE OF DEATH** April 2 1948, at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-1- 1948 to 4-2- 1948 and that I last saw h er alive on 4-2- 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	4 hrs.
Due to Chr. arteria sclerosis	yrs ?
previous Cerebral Hemorrhage	4 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. **Signature** N. J. Davidov M. D.
Address 3218 Elsteron Date signed 4-3-48

VS 150

X

G61886 Wo-4700

AB-58486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G61886

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 46yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 729 N. Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Cagle

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Col.	Separated

6 (b) Name of husband or wife Annie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28-1875

8. AGE: Years	Months	Days	If less than one day: hr.	min.
72				

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name George Cagle(D
13. Birthplace N.C.

MOTHER
14. Maiden Name Jane Montgomery (D
15. Birthplace N.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Johns Hopkins Medical School MAR 31 1948 Commissioner of Health

18 (a) Funeral director Robert E. Williams-1515 McElderry St.
(b) Address

19 APR 5 1948 (Date received by Registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29- 1948, at 1.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-18- 1940 to 3-19- 1948, and that I last saw him alive on 3-19- 1948

Immediate cause of death: Cerebral Hemorrhage — Duration: 7 yrs
Due to: Hypertension Cardio Vascular Renal — 1
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work?)
(e) Means of injury

23. Signature Richard Eliot, M.D.
Address B. C. H. Date signed 3/31/48

VS 150

X

Please write plainly. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66887 JL - 86990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓123

Registered No. 66887

Please write clearly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 18-W
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 W. Fairmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Cussenburg

3 (b) If veteran, name war | 3 (c) Social Security Account No

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. ? ? 1[illegible]

8. AGE: Years 65 ? | Months | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER: 12. Name ? 13. Birthplace ?

MOTHER: 14. Maiden Name ? 15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo MAR 31 1948 Commissioner of Health

18 (a) Funeral director
(b) Address Huntington Williams, MD

19 (Date rec'd by local Reg.) APR 5 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 19 48, at 4.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 16 19 48 to March 30 19 48, and that I last saw him alive on March 30 19 48

Immediate cause of death: Atelectasis following operation — Duration: 18 Hours

Due to

Due to

Other Conditions (Include pregnancy within 3 months of death)

Date of operation 3-19-48

Major findings of operation: Distended, redundant, sigmoid colon.

of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or Town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work?)
(e) Means of injury

23. Signature M. M. Lacy, M. D. (M. D.)
Address Baltimore City Hosp. Date signed 3-30-48

VS 150

X

G61888

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 937

Registered No. G61888

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital 4-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 417 N. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Finch

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr

8. AGE: Years 64 | Months | Days | If less than one day hr min

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?
13. Birthplace

MOTHER 14. Maiden Name ?
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo MAR 1 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) APR 5 - 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1948, at 11 PM

21. I certify that death occurred on the date above stated, that I attended deceased from March 3 1948 to March 20 1948, and that I last saw him alive on March 20 1948.

	Duration
Immediate cause of death Acute Cardiac decompensation	
Due to Arteriosclerosis Arteriosclerotic Renal disease	
Due to	
Other Conditions Decubitus ulcer, sacrum Dehydration, Contracted Kidney (include pregnancy within 3 months of death)	

Date of operation None

Major findings of operation:

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence Jr
Address University Hospital Date signed 3/23/48

661889 BC-48-06 623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

Registered 661889

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayn + Bukeland 27-11
(c) Hospital or institution West Baltimore Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5d
(e) Length of stay in Baltimore (yrs., mos., or days) 5d.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore 12
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5711 Whitelord Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Bull

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. 3-11-48

8. AGE: Years	Months	Days	If less than one day
0	0	5	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Edwin Bull
13. Birthplace Maryland

MOTHER
14. Maiden Name Helen Bumler
15. Birthplace Maryland

16. (a) Informant Helen Bull
(b) Address 5711 Whitelord Ave.

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical Schoo MAR 31 1948
Location Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) APR 5 - 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 16 48 (month) (day) 1948 at 4P M

21. I certify that death occurred on the date above stated, that I attended deceased from 3 11 48 to 3 16 1948, and that I last saw h alive on 3 16 48

Immediate cause of death: Respiratory Embarrassment — Duration

Due to Pressure on Trachea

Due to Thyroid Cyst

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3 12 48

Major findings of operation: Enlarged Thyroid Cyst

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norman Levin M. D.
Address Date signed

G61890

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 160a

Registered No. G61890

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2724 N. Charles St.
(c) Hospital or institution: Dolores Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Pikesville (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 - Sirona Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Schmedes / Schmedes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-28-48

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Schmedes
13. Birthplace Balto Md

MOTHER
14. Maiden Name Rose Wiesel
15. Birthplace Balto Md

16 (a) Informant Rose M. Schmedes
(b) Address 6 Sirona Pl. Pikesville

17 (a) (Burial, cremation, or removal)
(b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location

Johns Hopkins Medical Schoo MAR 29 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) APR 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-29 1948 at 2:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-28 1948 to 3-29 1948.
and that I last saw h[illegible] alive on 3-29 1948.

Immediate cause of death Ante partum Hemorrhage

Due to

Due to Breech Presentation

Other Conditions Small baby 4½ lbs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Nicholas Longfield M.D.
Address 5707 Belair Rd Date signed 3-29-48.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

C61891

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. C61891

KB-06894 107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 13-3
(a) Baltimore City, Maryland
(b) Street address Baynor and Dukeland St.
(c) Hospital or institution:
West Balt Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2923 Pennsylvania Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Booker

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-26-48

8. AGE: Years	Months	Days	If less than one day
		21	hr. min.

9. Birthplace Balt. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business —

MOTHER | FATHER

12. Name Terence Booker
13. Birthplace Baltimore, Md.
14. Maiden Name Virginia Davies
15. Birthplace Buchanon Va.

16 (a) Informant Virginia Davies
(b) Address 2923 Penna. Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) Apr 5 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 27 48 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3 [illegible] 19 48, to 3 27 19 48 and that I last saw h[illegible] alive on 3 [illegible] 19 48

Immediate cause of death	Duration
Cardiac Failure	
Due to Pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gordon Gray M. D.
Address Wage · Balt Gen. Hosp Date signed 3-27-48

VS .150 -

X

C61892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. C61892

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 836 W. Baltimore St.
(c) Hospital or institution: Sydenham Hosp 18-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 836 W. Baltimore St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME (Mrs) Irene Iva

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife James Iva Alive 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1 ? year

8. AGE: Years	Months	Days	If less than one day: hr.	min.
?47	5	24		

9. Birthplace Pheasant Corner (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name ?
13. Birthplace Unknown

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Irene Iva + (Beatrice Flowers)
(b) Address 836 W. Holland St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo MAR 31 1948
18 (a) Funeral director Commissioner of Health
(b) Address
19 (a) APR 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1948, at 12 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/19 1948 to 3/25 1948, and that I last saw her alive on 3/25 1948

	Duration
Immediate cause of death Intracranial Hemorrhage	? 12-24 hrs
Due to Generalized arteriosclerosis	?
Due to	
Other Conditions Labor pneumonia	1 week

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret M. Hammond M. D.
Address Sydenham Hosp. Date signed 3/25/48

V S 150

83a

661893

BC-48-07104

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. 661893

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13-6
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10½ HRS
(e) Length of stay in Baltimore (yrs., mos., or days) 10½ HRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTO
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3361 FALLS RD. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME LONNIE OTTIS HOWARD JR

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 24 MAR 1948

8. AGE: Years	Months	Days	If less than one day
0	0	0	10 hr 30 min

9. Birthplace BALTIMORE MD (Town, county, and state)
10. Usual Occupation NEWBORN
11. Industry or business

FATHER
12. Name LONNIE OTTIS HOWARD
13. Birthplace VA.

MOTHER
14. Maiden Name BERTHA MAE WISNER
15. Birthplace BALTIMORE MD

16 (a) Informant BERTHA MAE HOWARD
(b) Address BALTO MD

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo MAR 30 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 APR 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 MARCH 1948, at 5:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 24 MAR 1948 to 25 MAR 1948, and that I last saw him alive on 25 MAR 1948.

Immediate cause of death PREMATURE BIRTH — Duration
24½ WKS GESTATION - WEIGHT 1 lb 6 oz
Due to ABRUPTIO PLACENTA
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert King Schoenbucher M. D.
Address Med. Field Hosp Date signed 2 Aug 48

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G61894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 1937

Registered No. G61894

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3803 Harlem Ave
(c) Hospital or institution: 16-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3803 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles R Herbert

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Dec 31st 1900

8. AGE: Years	Months	Days	If less than one day hr	min
47	3	2		

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Baker
11. Industry or business Reinhardt's Bakery

FATHER
12. Name John J. Herbert
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary R. Ruff
15. Birthplace Germany

16 (a) Informant Mrs Mary R. Herbert
(b) Address 3803 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins St.

19 APR 5 - 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 193

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2nd 1948, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1948, to 4/1 1948 and that I last saw h alive on 4/1 1948

Immediate cause of death	Duration
Acute Coronary Insuff.	
Due to (b) Hypertension	
Due to (c) Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. L. Hornstein M.D.
Address 304 E. Biddle St. Date signed 4/5/48

X

G61895

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G61895

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Rural - Hollyrock Rd. Middle River Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa F. Savin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Mason Savin
6 (c) If alive, give age ~~dead~~ years

7. Birth date of deceased (mo., day, yr.) Sept 2, 1875

8. AGE: Years	Months	Days	If less than one day
72	7	1	hr. min.

9. Birthplace Maryland (Balto)
(town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Theodore Heinecke
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Hoff
15. Birthplace Germany

16 (a) Informant Mrs George H. Vandermast
(b) Address Hollyrock Rd. Middle River

17 (a) Burial (b) Date thereof 4/6/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Govans Presbyterian
Location Govans, Md.

18 (a) Funeral director John J. Gowan & Son
(b) Address 901-03 Hollins St.

19 (a) APR 5 - 1948 (b) Huntington Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1948, at 5 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1948 to April 3 1948, and that I last saw ~~her~~ alive on April 2 1948.

Immediate cause of death: Coronary occlusion — Duration: 16 hrs
Due to Arteriosclerotic Cardiovascular disease — over 5 yrs.
Due to Hypertension
Other Conditions none

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no)
(e) Means of injury

23. Signature D. Otis Montgomery M.D.
Address Mercy Hospital Date signed 4-3-48

VS. 150

G61896 Csl-4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G61896

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2-3
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2021 Fleet St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cleo Christ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr 1-14-32

8. AGE: Years	Months	Days	If less than one day
16	2	14	hr min

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Nick Christ
13. Birthplace Greece

MOTHER
14. Maiden Name Demetra ?
15. Birthplace Greece

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-5-48 (month) (day) (year)
(c) Cemetery or crematory Greek Cemetery
Location Windsor Mill Rd.

18 (a) Funeral director Lambros Funeral Home Inc
(b) Address 440 E. North ave

19 (Date received by Registrar) APR 5 1948 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-1 1948 at 950 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 3-31 1948 to 4-1 1948, and that I last saw her alive on 4-1 1948

Immediate cause of death: Embolism to left cerebral hemisphere
Due to Auricular fibrillation
Due to Chr. rheumatic heart disease E M.S., M.i., A.i.
Other Conditions

Duration: 24 hrs. / 2 mos.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Victor A. McKusick
Address Johns Hopkins Hosp. Date signed 4/2/48

VS 150

X

G61897

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 467

Registered No. G61897

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 331 ROSEBANK AVE
(c) Hospital or institution:
27-12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 331 ROSEBANK AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT EDWIN KIRK

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	Yes

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	MARRIED

6 (b) Name of husband or wife JENNIE F NEE HUNT
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) APR 1, 1877

8. AGE: Years	Months	Days	If less than one day
71	0	1	hr. min.

9. Birthplace BALTO, MD (Town, county, and state)
10. Usual Occupation
11. Industry or business ALLIED PAPER BAG Co

FATHER
12. Name ROBERT E KIRK
13. Birthplace BALTO, MD

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant MRS JENNIE F KIRK WIFE
(b) Address 331 ROSEBANK AVE

17 (a) BURIAL (b) Date thereof 4/5/48 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ LEVANS METHODIST CEM
Location BALTO, MD

18 (a) Funeral director WM J TONER & SON
(b) Address BALTO, MD

19 (a) APR 5 - 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/2/1948, 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1947 to April 2 1948.
and that I last saw h[illegible] alive on 4/1/1948

Immediate cause of death: CANCER OF RECTO-SIGMOID — Duration: 1 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Charles F O'Donnell M.D.
Address 7301 York Rd Date signed 4/5/48
Towson X

G61898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G61898

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2136 Penrose Ave
(c) Hospital or institution: 70-7

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2136 Penrose Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cosona D. Mass

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife Vincent F. Mass
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 20, 1868

8. AGE: Years	Months	Days	If less than one day: hr.	min.
79	6	11		

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Stephen Ayers
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Souder
15. Birthplace Md.

16 (a) Informant Mrs. Wallace V. Petersen
(b) Address 2136 Penrose Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director Wm. J. Tucker & Sons
(b) Address Balto. Md.

19 APR 5 - 1948 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 1 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1947 to April 1 1948 and that I last saw h-r alive on Mar 31 1948.

Immediate cause of death Chronic Myocarditis

Due to Infirmities of

Due to old age

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy:

Duration
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Walter E. Krichman M.D. M.D.
Address 225 Murdoch Rd Date signed April 3 1948

Turlington Williams, M.D.

VS 150

X

C61899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C61899

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2841 WOODBROOK AVE
(c) Hospital or institution:
12-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2841 WOODBROOK AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE W. BELL

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
NO	NO	M	W	MARRIED

6 (b) Name of husband or wife EMMA NEE SCOTT
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) AUG 10 - 1870

8. AGE: Years	Months	Days	If less than one day hr.	min.
77	7	21		

9. Birthplace BALTO. MD (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business B&O RR

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant MRS. LOTTIE DIXON
(b) Address 1826 N. BOND ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/3/48 (month) (day) (year)
(c) Cemetery or crematory WESTERN
Location BALTO, MD

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTO., MD.

19 (a) APR 5 - 1948 (Date rec'd by registrar) Registrar

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/1/48 at 6:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1948 to 4/1 1948 and that I last saw him alive on 4/1 1948.

Immediate cause of death acute sclerotic cardio renal disease — Duration 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M.D.
Address 2030 Wilkens Ave Date signed 4/2/48

X

G61900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 577

Registered No. G61900

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15-3
(c) Hospital or institution: Johns Hopkins Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1645 Thomas Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barrie Bober

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife —

6 (c) If alien, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
14			min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER — 12. Name	Leon Bober
FATHER — 13. Birthplace	Russia
MOTHER — 14. Maiden Name	Elsie
MOTHER — 15. Birthplace	Balto Md

16 (a) Informant Leon Bober
(b) Address 1645 Thomas Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-5-48 (month)

(c) Cemetery or crematory
Location Hebrew Mt Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 2160 Eutaw Place

19 (Date rec'd by Registrar) APR 5 - 1948 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4th 1948, at 1:55 P.M.

21. I certify that I took charge of the remains described above, held an Inq Ed Insp thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Brain tumor

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (While at work?)
(d) Means of injury

23. Signature William G Kelly Medical Examiner
Date signed 4/4/48

VS 151

G61901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G61901

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3231 Erdman Ave
(c) Hospital or institution: 2(-3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3231 Erdman Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Joseph Dressel

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-03-4039

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary A. Dressel
6 (c) If dead, give age years

7. Birth date of deceased (mo., day, yr.) June 24 - 189[illegible]

8. AGE: Years	Months	Days	If less than one day
77	9	8	hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Dressel
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Wellbert
15. Birthplace Germany

16 (a) Informant Mrs Mary A Dressel
(b) Address 3231 Erdman ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-6-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Leo J Herrmann
(b) Address 3001 Pinkney ave

19 (a) [illegible] (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1948 at 5 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov. 1947 to April 2 1948
and that I last saw [illegible] alive on April 2 1948.

Immediate cause of death: Cerebral Hemorrhage. — Duration
Due to Arteriosclerotic Cardio-Vascular disease
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) (While at work)
(e) Means of injury

23. Signature L G Stevens, M.D.
Address 540 Cathedral St Date signed 4/5/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

661902

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 48B

Registered No. 661902

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1209 Ashland Ave
(c) Hospital or institution: 10-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 Ashland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anita V. Pleasant
3 (b) If veteran, name war
3 (c) Social Security Account No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Col.	Widow

6 (b) Name of husband or wife John
6 (c) If alive, give age years
7. Birth date of deceased mo., day, yr. Nov 11, 1887

8. AGE: Years	Months	Days	If less than one day
60			hr. min

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George James
13. Birthplace Md.

MOTHER
14. Maiden Name Laura Chase
15. Birthplace Md.

16 (a) Informant Florence Gilbert Chandler
(b) Address 1209 Ashland Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof April 6/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Frederick Road
18 (a) Funeral director Mrs Robt A. Ellinor Dept
(b) Address 113 W. Franklin St.
19 APR 5 - 1948 (Date rec'd by registrar) (b) Twitington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-3 1948 at 9:30 P.M.
21. I certify that death occurred on the date above stated, that I attended deceased from 1/13 1948 to 4/3 1948
and that I last saw h[illegible] alive on 4/2 1948

Immediate cause of death
a Lung - Carcinoma
Fundus of uterus

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

Duration
6 mos.

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature RAYNER BROWNE, M.D. Date signed 4/8/48
Address 1500 EAST MADISON ST.
BALTIMORE 5, MD.

VS 150

G61903

G61903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 10-2
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 810 N. Gay Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Fauson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William Fauson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 8, 1884

8. AGE: Years: 64 | Months: 1 | Days: 21 | If less than one day: hr. min.

9. Birthplace: Manning S.C. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Elmer Evans
13. Birthplace: S.C.

MOTHER
14. Maiden Name: Minda ?
15. Birthplace: S.C.

16 (a) Informant: Levine Swinton
(b) Address: 517 E. Biddle Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5 48
(c) Cemetery or crematory: Mt Calvary Cem.
Location: A.A. County

18 (a) Funeral director: McCott A. Ellicott Dept
(b) Address: 1129 N. Carrollton St.

19 (a) APR 5 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1948 at 6 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy & Inq. thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (Specify)
(d) Means of injury

23. Signature Carl A. Royer M.D. Medical Examiner
Date signed 4-1-48

VS 151

G61904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

G61904 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2244 SIDNEY AVE.
(c) Hospital or institution: 25-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 7/12 YRS
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 2244 SIDNEY AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HENRY HARTMAN.

3 (b) If veteran, name war: SPANISH WAR.

3 (c) Social Security Account No. 216-05-5202

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	WHT	MARRIED.

6 (b) Name of husband or wife: HILMA HARTMAN
6 (c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): SEPT. 7. 1877.

8. AGE: Years	Months	Days	If less than one day: hr.	min.
70	6	22		

9. Birthplace: HESSEN GERMANY (Town, county, and state)
10. Usual Occupation: GLASS WORKER.
11. Industry or business: CARR-LOWREY GLASS CO

MOTHER / FATHER
12. Name: GEO. HARTMAN
13. Birthplace: GERMANY
14. Maiden Name: ELIZABETH DEBUS.
15. Birthplace: GERMANY

16 (a) Informant: HILMA HARTMAN
(b) Address: 2244 SIDNEY AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: 4-7-1948 (month) (day) (year)
(c) Cemetery or crematory: LOUDON PK.
Location: FREE AVE

18 (a) Funeral director: GEO. LEIMBACH
(b) Address: 525 N. LYNNHURST ST

19 (a) APR 5 - 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April - 4 - 1948 at 12.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 1946 to April-3. 1948. and that I last saw h. alive on April-3-1948.

Immediate cause of death: Cancer of larynx — Duration

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Walter K. Sonnenfeld M. D.
Address: 2708 Hollins Ferry RD Date signed: 5/4/48

VS 130

X

C61905

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 166

C61905 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore County (If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 Chesco Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Telljohann
3 (b) If veteran, name war
3 (c) Social Security Account No. ?

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced MARRIED
6 (b) Name of husband or wife HENRY -
6 (c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) 7-31-1893
8. AGE: Years 54 | Months 8 | Days 2 | If less than one day hr. min.
9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business HOME

FATHER
12. Name CHARLES BUSSE
13. Birthplace ?

MOTHER
14. Maiden Name BERTHA KRAUSE
15. Birthplace ?

16 (a) Informant HENRY TELLJOHANN
(b) Address 1213 CHESACO AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-6-1948 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director LILLY & ZEILER INC.
(b) Address 403 S. WOLFE ST.

19 (a) APR 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1948, at 1 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Bullet Wound of Chest, Thigh & Abdomen -

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-31-48 at 11 P. M.
(b) Where did injury occur? 201 Blk. S. East Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Gun Shot Wound

23. Signature [signature] M.D. Medical Examiner
Date signed 4-3-48

VS 181

G61906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G61906

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 711 S. Hanover
(c) Hospital or institution: 22-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 S. Hanover (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME John Wesley
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Sadie Wesley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Texas (Town, county and state)
10. Usual Occupation Barber
11. Industry or business

FATHER
12. Name Jack Wesley
13. Birthplace Texas

MOTHER
14. Maiden Name unk
15. Birthplace unk

16 (a) Informant Sadie Wesley
(b) Address 711 S. Hanover

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 7-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James A Davis
(b) Address 142 W Saratoga St

19 (a) APR 5 - 1948 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 3 1948 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1947 to April 3 1948
and that I last saw him alive on April 3 1948.

Immediate cause of death Pulmonary Tuberculosis — Duration 6 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. W. [illegible] M.D.
Address 715 Wilmington Ave Date signed 4-5-48

V S 150

G61907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124B

Registered No. G61907

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Green & Redwood Sts

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland County Howard

(c) City or town Ellicott City (If outside city or town limits, write RURAL and give town)

(d) Street No. College Ave. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Alfred Victor Weaver

3 (b) If veteran, name war None

3 (c) Social Security Account No. 215-01-8903

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Gertrude Ballist Weaver NEE Kline | If alive, give present address: Deceased

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1878

8. AGE: Years: 69 | Months: 7 | Days: 10 | If less than one day: hr. ___ min.

9. Birthplace Center Valley, Penna. (Town, county and state)

10. Usual Occupation Secty. & Asst. Treas.

11. Industry or business Insurance Co. Retired

MOTHER | FATHER

12. Name John R. Weaver

13. Birthplace Pennsylvania

14. Maiden Name Ellen S. Huff

15. Birthplace Pennsylvania

16 (a) Informant Mrs William F. Sauerwein

(b) Address Ellicott City Md.

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof Apr. 5 1948 (month) (day) (year)

(c) Cemetery or crematory Lorraine Masoleum

Location Woodlawn, Md.

18 (a) Funeral director Easton Sons

(b) Address Ellicott City Md.

19 (a) APR 5- 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/2 1948, at 6 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1948 to 4/2 1948. and that I last saw h alive on 4/2 1948.

Immediate cause of death: Resp Failure

Due to B/L Lob Pneumonia

Due to Cirrhosis

Other Conditions Jaundice Arteriosclerosis

(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 10 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature R. A. Neuhauser, M.D. M. D.

Address Date signed

VS 150

061908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127B

Registered No. 061908

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Fairlawn Ave.
(c) Hospital or institution: Maryland General Hosp. 27-16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4543 Pimlico Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mrs. Margaret Colby

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John R. Colby | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible] 1870

8. AGE: Years 77 | Months 10 | Days 16 | If less than one day: hr. / min.

9. Birthplace W. Va (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name David Brown
13. Birthplace Scotland

MOTHER
14. Maiden Name Jane Ayers
15. Birthplace Scotland

16 (a) Informant Mrs Katherine Baker
(b) Address 4543 Pimlico Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-5-48 (month) (day) (year)
(c) Cemetery or crematory Mt Olive Cemetery
Location Randallstown, Md.

18 (a) Funeral director Loring Bryce
(b) Address 5005 Park Heights Ave

19 (a) APR 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 April 1948, at 8:25 p M

21. I certify that death occurred on the date above stated; that I attended deceased from 29 March 1948, to 2 April 1948, and that I last saw her alive on 2 April 1948.

Immediate cause of death: Biliary Obstruction — Duration: Approx 10 days

Due to: Undetermined (either stone or malignancy)

Due to:

Other Conditions: Arteriolar fibrillation — Duration: ?

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature M. T. McGonigle

Address Maryland Gen. Hospital Date signed 2 M April D 1948

X

661909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 97

Registered No. 661909

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton + Wilkens

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1915 Halethorpe Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Mrs. Margaret E. White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Now Widow

6 (b) Name of husband or wife Dale Frank M.

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr 3. 31. 1872

8. AGE: Years 76 | Months - | Days 4 | If less than one day hr. min.

9. Birthplace Chicago Ill. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph Schmidt

13. Birthplace Germany

MOTHER 14. Maiden Name Margaret Hess

15. Birthplace New York

16 (a) Informant: Frank M. White Jr.

(b) Address 1915 Hale Hope Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4. 5. 48. (month) (day) (year)

(c) Cemetery or crematory

Location Chicago Ill.

18 (a) Funeral director Harry A. Welsh

(b) Address 4101 Edmondson

19 APR 5 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4 1948 at 10.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/4 1948 to 4/4 1948 and that I last saw her alive on 19

Immediate cause of death Heart failure — Duration

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Hugh A Wells

Address St Agnes Hosp. Date signed 4/7/48 M. D.

VS 193

for F.C.J. Zurinski, Howard J. Mallis, M.D. CC

C61910
AB-118210

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. C61910

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 1day?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 718 Ensor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME John Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Col.	?

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr ?-?-?

8. AGE: Years	Months	Days	If less than one day hr.	min
75?				

9. Birthplace ? (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location Johns Hopkins Medical Schoo MAR 4 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

APR 5 - 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17- 1948, at 9.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-16 1948 to 3-17- 1948 and that I last saw him alive on 3-17- 1948.

Immediate cause of death	Duration
Bronchopneumonia	1wk
Due to (b) Cardiac Failure	
Due to (c) Arteriosclerotic Heart Disease	yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work)
(e) Means of injury

23. Signature [signature] M. D.
Address [illegible] Date signed 3/23/48

VS 193

C61911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C61911

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Pl — 27.10
(c) Hospital or institution: Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5104 IVANHOE AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ellen F. Krauss

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	W.

6 (b) Name of husband or wife THEADORE A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30, 1871

8. AGE: Years	Months	Days	If less than one day: hr.	min.
77	0	4		

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation AT HOME
11. Industry or business

FATHER
12. Name Philip Cashmyer
13. Birthplace BALTIMORE

MOTHER
14. Maiden Name Mary Miller
15. Birthplace BALTIMORE

16 (a) Informant Sister Superior Home for Poor
(b) Address 1200 Valley St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/6/48 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location [redacted] OLD FREDK. RD.

18 (a) Funeral director CLARENCE F. HOFFMANN
(b) Address 1639 BROADWAY Huntingtown Williamsport, Md.

19 (a) Date received by Registrar APR 6 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1948, at 1:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 22 1948, to April 3 1948, and that I last saw her alive on April 3 1948.

Immediate cause of death	Duration
Edema Lungs	1 Day
Due to Chronic Myocarditis	4 yrs
Due to	
Other Conditions Chronic Nephritis	6 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no) (place)
(e) Means of injury
23. Signature E. Gill Hall M. D.
Address 1631 E. Fayette St. Date signed 4/3/48

VS 180

X

61912 — 5-61912

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH — Registered No. 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4-1
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 48 Market Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME H. LAMPKIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 50 | Months | Days | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School MAR 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 APR 5 - 1948 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1948 at 2 15 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Lobar pneumonia
Fatty degeneration of liver
~~Due to~~ Chronic alcoholism.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 3/18/48

VS 151

C61913

48-15252

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1612

C61963

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Streets
(c) Hospital or institution: Univ of Md. Hosp. 15-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1653 McKean Ave Balt #17
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Johns

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Infant.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-9-48

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Univ of Md Hosp. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name David Johns
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Margaret Collins
15. Birthplace Baltimore, Md.

16 (a) Informant Mother.
(b) Address 1653 McKean Ave - Balt. #17

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory

18 (a) Funeral director
(b) Address

19 APR 5 - 1948 (Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1948, at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 7 1948, to March 10 1948, and that I last saw him alive on March 10 1948.

Immediate cause of death Cerebral Anemia
Sclerema Neonatorum

Due to

Due to

Other Conditions Cleft palate; hair lip.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Long M. D.
Address University Md. Hospital Date signed 3-16-48
Balt. Md.

for Johns Hopkins Medical School MAR 19, 1948
Commissioner of Health

Hunter H. Williams, M.D.

661914

AB-118287

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

A3B

Registered 661914

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
J-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 24years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 624 Redwood St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leroy Terry-

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18- 1905

8. AGE: Years	Months	Days	If less than one day: hr.	min.
43	-	2		

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name Major Terry
13. Birthplace Va.

MOTHER
14. Maiden Name Eva Mitchell
15. Birthplace Va.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo MAR 31, 1948
18 (a) Funeral director Commissioner of Health
(b) Address
19 APR 5 - 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20- 19 48 at 12.20 AM PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-19- 1948 to 3-20- 1948 and that I last saw h im alive on 3-20- 1948.

Immediate cause of death	Duration
Pulmonary Tuberculosis	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp Date signed 3-23-48

X

yw 150

FILLING WITH PENCIL, WITH CARBON INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G61915

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G61915

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3-1
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos. or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1526 E. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wesley Catamon (Cattamon)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 5 1889

8. AGE: Years	Months	Days	If less than one day
(63) 58	6	8	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Johns Hopkins Medical Schoo MAR 24, 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) APR 5 - 1948 (Date rec'd by registrar) (b) Hunter for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1948, at 7 31 PM

21. I certify that I took charge of the remains described above, held an Insp. & Ly Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Myocardial Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L Pope M.D. Medical Examiner
Date signed 9-11-48

C61916

C 48-15137

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 157E

C61916
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2833 Spellman Road
(c) Hospital or institution: 25-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2833 Spellman Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miles Edwards

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
—	—	—	1 hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Earle Norman Edwards
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Evelyn Grace Neigh
15. Birthplace Baltimore, Md.

16 (a) Informant Evelyn Neigh
(b) Address 2833 Spellman Road

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Johns Hopkins Medical Schoo MAR 24 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) APR 5 - 1948 (b) Hunter for Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7, 1948 at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH
Congenital malformation of heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Geo. G. Merrill M.D.
Medical Examiner.
Date signed 3-16-48

VS 181

G61917

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G61917

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2103 Gough Street
(c) Hospital or institution: Home 1-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 31 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2103 Gough Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Josephine Danilak (Danielak)

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband: ~~XXXXX~~ Joseph Dec'd

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12, 1872 ?

8. AGE: Years 75 ? | Months | Days 15 | If less than one day: hr. min.

9. Birthplace: Poland (Town, county and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Martin Puchalski
13. Birthplace: Poland

MOTHER
14. Maiden Name: Mary Majerowski
15. Birthplace: Poland

16 (a) Informant: Frank Danielak (Son)
(b) Address: 2103 Gough Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-8-48 (month) (day) (year)
(c) Cemetery ~~XXXXXXX~~ St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director: George A. Weber
(b) Address: 705 South Ann Street

19 (a) APR 5 - 1948 (Date received by registrar) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4th 1948, at 6.40 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 4 1948 to April 4 1948 and that I last saw her alive on April 4 1948.

Immediate cause of death: CEREBRAL HEMORRHAGE — Duration: 4/1/48

Due to: ARTERIO SCLEROTIC-HYPERTENSIVE CARDIO-VASCULAR, VALVULAR DISEASE — 1/4/48

Other Conditions: TERMINAL BRONCHO-PNEUMONIA — 4/2/48

(Include pregnancy within 3 months of death)

Date of operation: NONE

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(e) Means of injury

23. Signature: Joseph F. Danielak
Address 209 S. Eden St Date signed 4/5/48

VS 15)

G61918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G61918 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1774 Montpelier Street
(c) Hospital or institution: 9-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1774 Montpelier Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE EDWARD THUMSER

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Gertrude E. Thumser
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) July 23, 1879

8. AGE: Years	Months	Days	If less than one day
68	8	10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business So. Label Box Corp.

FATHER
12. Name George Thumser
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Clara Gisel
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Gertrude E. Thumser
(b) Address 1774 Montpelier Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE & BROADWAY

19 (a) APR 5 - 1948 (Date rec'd by registrar) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1948 8.45P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-21- 1939 to 2-14-1948 and that I last saw him alive on 2-14 1948

Immediate cause of death	Duration
Cerebral Apoplexy	30 min.
Due to Generalised Arterio Sclerosis	1939
Due to Diabetes Mellitus	1939
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton C. Carey M. D.
Address 2117 Belair Rd Date signed 4-4-48

VS 150

X

C61919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

C61919 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 815
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1820 N. Rutland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Kessler (KATIE THOMPSON KESSLER

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 213-10-1448

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William T. Kessler

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 23, 1877

8. AGE: Years: 70 | Months: 5 | Days: 8 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: James Vain
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Fannie Smith
15. Birthplace: Maryland

16 (a) Informant: Mrs. Fannie Connolly
(b) Address: 1820 N. Rutland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/6/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/2 1948 at 9:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pontaneactatic C.V
disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed 4/13/48

APR 13 1948

VS 181

661920

BC-48-01028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 661920

PRESS WRITE FIRMLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A
(c) Hospital or institution: Mercy Hospital 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1431 (John St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wanda Stilson 48-01028

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/6/48

8. AGE: Years	Months	Days	If less than one day
	2	13	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School MAR 24 1948
Commissioner of Health

18 (a) Funeral director
(b) Address APR 5 - 1948 Huntington Williams, M.D.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/19 1948 at 7:40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions (Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 3/19/48

G61921 JL- 118136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 186a

Registered No. G61921

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 21days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2606 Taylor Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dora Isabelle Gilbert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24th 1861

8. AGE: Years	Months	Days	If less than one day
86	8	19	hr. min.

9. Birthplace Md. Harford Co. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Joshua Griffin
13. Birthplace Md.

MOTHER
14. Maiden Name Sema Numbers
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) APR 5 - 1948 (Date rec'd by registrar) (b) Clinton Williams M.D. To be approved by Medical Examiner

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1948, at 10.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 13 1948 to April 13 1948, and that I last saw her alive on April 3 1948.

Immediate cause of death	Duration
Arteriosclerotic cardio-vascular disease with myocardial fibrosis	
Due to	
Due to	
Other Conditions Intertrochanteric fracture, left femur (Include pregnancy within 3 months of death)	2 wks

Date of operation

Major findings of operation:

of autopsy no autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: accident
(a) Accident, suicide, or homicide
(b) Date of occurrence 3/14/48 at M
(c) Where did injury occur? Baltimore Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? at home While at work? No (Specify type of place)
(e) Means of injury Fell out of bed

23. Signature C. S. Carlson M.D.
Address Baltimore City Hospitals Date signed 4/3/48

Medical Examiner
for C. M. Davis M.D.
Samuel J. Madalis M.D.

C61922
448102

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 137a

Registered No. C61922

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 21-1
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 601 W. Hamburg St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Lambdin
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Minnie Lambdin (Carroll)
6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) Dec. 29 (1870)

8. AGE: Years 77 | Months 3 | Days 14 | If less than one day: hr. min.

9. Birthplace Md., Baltimore (Town, county, and state)

10. Usual Occupation Retired Maintainence
11. Industry or business Mary Harrod's, Kelly Hosp.

MOTHER / FATHER
12. Name Thomas Lambdin
13. Birthplace Md
14. Maiden Name Mary Barringer
15. Birthplace Md.

16 (a) Informant records & Wife
(b) Address JOHNS HOPKINS HOSPITAL 601 W. Hamburg

17 (a) Burial — (Burial, cremation, or removal) (b) Date thereof Wed-Apr 7-48 (month) (day) (year)
(c) Cemetery or crematory Leder Hill Cem. Location Arcadia

18 (a) Funeral director Raymond Evans
(b) Address 1400 S Charles St Baltimore

19 (a) APR 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April - 4 - 1948 at 5:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-31- 1948 to 4-4- 1948. and that I last saw him alive on 4-4- 1948.

Immediate cause of death UNKNOWN — Duration

Due to arteriosclerosis

Due to senility ?

Other Conditions Re-Admitted in Coma on 3-31-48 (Include pregnancy within 3 months of death)

Date of operation 1-7-48

Major findings of operation: Benign Prostatic Hypertrophy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Hospital Date signed 4/4/48

VS 130

X

G61923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G61923

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1715 W. Pratt St
(c) Hospital or institution: 19-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 W. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie C. Flynn

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John C. Flynn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 1868

8. AGE: Years 79 | Months 3 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or Business

FATHER 12. Name Charley Kammer

13. Birthplace Germany

MOTHER 14. Maiden Name Katherine Sitzer

15. Birthplace Germany

16 (a) Informant Katherine M. Simpson

(b) Address 1715 W. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 7. 1948 (month) (day) (year)

(c) Cemetery or crematory Westview Park

Location Balto Md

18 (a) Funeral director H. C. & B. M. Walter

(b) Address 1601 Stricker St

19 APR 5 - 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5th 1948 at 12 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1948 to April 5 1948 and that I last saw him alive on April 4 1948.

Immediate cause of death Cardiac failure.

Due to Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Albert Sargent

Address 1724 W Lanvale St Date signed 4/5/48 M D

VS 150

G61924

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G61924

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14-3
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2229 Brunt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John H. Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	M

6 (b) Name of husband or wife Blanche

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-30-1904

8. AGE: Years	Months	Days	If less than one day: hr.	min.
43	6	5		

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business Bowling Alley

FATHER
12. Name John Thomas
13. Birthplace Baltimore

MOTHER
14. Maiden Name Sadie Featherbury
15. Birthplace Baltimore

16 (a) Informant Harry Smith (4)
(b) Address 814 Leadenhall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-8-48 (month) (day) (yr.)
(c) Cemetery or crematory Mt Auburn Ct
Location Baltimore City

18 (a) Funeral director Isaiah K. Brown & Son
(b) Address 105 W Montgomery St

19 (a) APR 6 - 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1941, at 2:00 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Pulmonary Edema
Hypertensive C.V. Disease
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl Long M.D. Medical Examiner.
Date signed 9-6-48

VS 151

BC-F 73715

G61925

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G61925

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Glen Burnie (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 Maple Lane (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No) If yes, name country

3 (a) FULL NAME DOROTHEA CRISPENS

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife: none
6 (c) If alive, give age ..... years

7. Birth date of deceased mo., day, yr. April 10, 1943

8. AGE: Years	Months	Days	If less than one day: hr.	min.
4	11	24		

9. Birthplace Glen Burnie, A.A.Co., Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John Crispens
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elsie G. Stinchcomb
15. Birthplace Anne Arundel County

16 (a) Informant Mrs. Elsie Crispens
(b) Address 406 Maple Lane Glen Burnie

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 7, 48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

19 (a) Apr 5 1948 (Date received by registrar) (b) Huntington Middle Mc Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1948, at 12:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from April 3 1948 to April 4 1948, and that I last saw him alive on April 4 1948

Immediate cause of death VASOMOTOR COLLAPSE

Due to WATERHOUSE FRIEDRICH-SEN SYNDROME

Due to SEPTICEMIA: MENINGITIS PROBABLY DUE TO MENINGOCOCCUS

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Subinsky M.D.
Address 1 W Baltimore Comml Date signed 4/4/48

G61926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

X G61926 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne - Arundel
(c) City or town Old Annapolis Rd. (If outside city or town limits, write RURAL and give town)
(d) Street No. Glen Burnie Md. Box 71-A (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Louis Johns

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/12/48

8. AGE: Years	Months	Days	If less than one day
	1	21	hr. min.

9. Birthplace Glen Burnie Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Floyd L. Johns
13. Birthplace Virginia

MOTHER
14. Maiden Name Helen Branham
15. Birthplace Virginia

16 (a) Informant Mrs. Helen Johns
(b) Address Glen Burnie, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 7, 1948 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie Md.

19 (a) APR 5 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 4 1948, at 11 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4 - 4 1948, to 4 - 4 1948 and that I last saw him alive on 4 - 4 1948.

Immediate cause of death	Duration
Respiratory failure	3 hours
Due to Congenital atelectasis	2 weeks 2 weeks
Due to Prematurity	2 weeks
Other Conditions Malnutrition	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gilbert H. Carouge
Address 6226 Everall Ave Date signed 4-6-48

VS 150

X

61927

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 50

Registered No. 61927

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 27-5
(b) Street address 33d & N. Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6420 Belair Rd., Balt. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. ~~Andrew J.~~ Edythe Easter

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife Andrew J. Easter
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 12-5-'99

8. AGE: Years	Months	Days	If less than one day: hr.	min.
48	3	30		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John H. McIver
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Lee McCain
15. Birthplace —

16 (a) Informant A.J. Easter
(b) Address 6420 Belair Rd.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 4/7/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Lanahan Funeral Home
(b) Address 7401 Belair Rd.

19 (a) APR 5 - 1948 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 4 1948 at 7:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-7 1948 to 4-4 1948 and that I last saw her alive on 4-4 1948

Immediate cause of death: Cerebral metastasis — Duration: 2 mo
Due to Cancer of breast — 3 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work)
(e) Means of injury

23. Signature J. Russell Shearer M. D.
Address 1400 Eutaw Place Date signed 4-4-48

VS 150

1400 X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

G61928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. G61928

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 26-5
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 64
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 343 S. Draw ST (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Erhardt

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-06-9540.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Mildred Erhardt

6 (c) If alive, give age — years

7. Birth date of deceased mo., day, yr July 2 - 1907

8. AGE: Years 40 Months 9 Days - If less than one day hr min

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Sink Cook.

11. Industry or business Am. Smelting & Refin.

FATHER 12. Name George Erhardt

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Elizabeth Hessler

15. Birthplace Balto. Md.

16 (a) Informant Mildred Erhardt

(b) Address 343 S Draw ST.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof April 4 1948. (month) (day) (year)

(c) Cemetery or crematory Sacred Heart.
Location Loppes Road.

18 (a) Funeral director Mildred Luppel

(b) Address 312-0 Highland Ave Huntington Williamsport, Md

APR 5 1948 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1948 at 2° P M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan. 29 1948 to April 2, 1948 and that I last saw him alive on April 2, 1948

Immediate cause of death: Respiratory Failure — Duration: ?
Immediately after RT Pneumonectomy
Due to Atelectasis — ?
Due to Bronchial Obstruction — ?
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation April 2, 1948 - RT pneumonectomy
Major findings of operation: Pulmonary Carcinoma
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Joseph Li Rica
Address Mercy Hosp. Date signed 4/2/48

VS 191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

661929

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 194a

Registered No. 661929

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 W. Franklin Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Magdalena Bornhorn

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-4173

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Oct. 18, 1898

8. AGE: Years	Months	Days	If less than one day
49	5	16	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Sales Lady
11. Industry or business Hutzler Bros.

FATHER
12. Name Bernard P. Bornhorn
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna C. Rott
15. Birthplace Balto. Md.

16 (a) Informant Mr. Ludger Bornhorn
(b) Address 202 Hopkins Road,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-6-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (c) APR 5 - 1948 (Date rec'd by registrar) Huntington Williams, M.D.

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Death 1948, and that I last saw her alive on Apr 1948.

Immediate cause of death: Coronary Thrombosis — Duration: 1 hour
Due to
Due to
Other Conditions: Hypertension — Duration: 5 years +

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alan Bernstein M. D.
Address 1109 N Calvert St Date signed

X 4/5/48

The C061930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

58B

Registered No. C61930

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Pr. George
(c) City or town (Rural) Suitland (If outside city or town limits, write RURAL and give town)
(d) Street No. 5010 Silver Hill Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3. (a) FULL NAME Mary Shaw
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Black	single

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 19, 1942

8. AGE: Years 6 | Months 2 | Days 16 | If less than one day: hr. min.

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas B Shaw
13. Birthplace Virginia

MOTHER
14. Maiden Name Louisa Thomas
15. Birthplace Maryland

16 (a) Informant
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4-5-48 (month) (day) (year)
(c) Cemetery or crematory Evergreen Cem.
Location Bladensburg Md.

18 (a) Funeral director T. Gasch & Sons
(b) Address Hyattsville, Md.

19 (a) APR 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 1-51

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1948 at 10:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-30 1948 to 4-4 1948 and that I last saw her alive on 4-4 1948.

Immediate cause of death Congestive Heart failure — Duration

Due to Mitral Stenosis & Insufficiency

Due to Rheumatic Heart Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Hightower M. D.
Address Univ. of Md. Hospital Date signed 4-4-48

G61931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G61931 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2913 KIRK Avenue
(c) Hospital or institution: 9-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2913 Kirk Avenue
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Henry C. RELLEKER

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife CHARLETTE E (nee FRITZ)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 12 [illegible]

8. AGE: Years 69 | Months - | Days 23 | If less than one day hr. min.

9. Birthplace BALTO
(Town, county, and state)

10. Usual Occupation —

11. Industry or business U.S. GOVT MARINE HOSP

FATHER
12. Name GEO RELLEKER
13. Birthplace BALTO. MD

MOTHER
14. Maiden Name MARY YOUSE
15. Birthplace BALTO. MD

16 (a) Informant MRS CHARLETTE E RELLEKER
(b) Address 2913 KIRK AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/8/48 (month) (day) (year)

(c) Cemetery or crematory BALTO., MEM.
Location BALTO., MD.

18 (a) Funeral director WM. T. ICKNER SONS
(b) Address BALTO., MD.

APR 5 1948

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4/48 19 8:45P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Lewis M.D.
Medical Examiner
Date signed 4/4/48

VS 151

G61932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G61932 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 512 E. 41ST ST.
(c) Hospital or institution: 9-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 E. 41ST ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEO. W. BRADFORD Wm Funeral Home

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced WIDOWED

6 (b) Name of husband or wife GEORGIANNA N.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) SEPT. 19, 1881

8. AGE: Years 66 | Months 6 | Days 25 | If less than one day hr. min.

9. Birthplace Pa.
(Town, county and state)

10. Usual Occupation FARMER

11. Industry or business

FATHER 12. Name Wm F. BRADFORD
13. Birthplace Pa.

MOTHER 14. Maiden Name RACHEL WILLIAMS
15. Birthplace [redacted] Pa.

16 (a) Informant MR. ERNEST S. BRADFORD
(b) Address 512 E. 41ST ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/7/48 (month) (day) (year)
(c) Cemetery or crematory FORK. M.E.
Location FORK, MD

18 (a) Funeral director Wm F. TICKNER & SON'S
(b) Address BALTO MD.

19 (a) APR 5 1948 (Date filed by registrar) (b) Huntington Williams Hospital

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4/ 1948, at 8:20 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1946, to April 4 1948, and that I last saw h/m alive on April 2 1948.

Immediate cause of death cardiac failure

Due to arterio-Sclerotic Heart Dis.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: arterio-Sclerotic heart disease, right sided hypertrophy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Crawford N. Kirkpatrick, Jr. M.D.
Address 6 E. Edgar Street Date signed 4-4-48

VS 150

Funeral must not proceed without permit. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C61933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

104

C61933

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3504 Howard Park Ave

(c) Hospital or institution: 28-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 38 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3504 Howard Park Ave

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) **FULL NAME** Helen Marcia Rogers ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife John Hobbs Rogers

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) April 8, 1948

8. AGE: Years 54 | Months 11 | Days 26 | If less than one day: hr. | min. 19 27

9. Birthplace Chestnut Ridge, Lutherville, Balto. Co., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Clarence W. Price

13. Birthplace Maryland

MOTHER

14. Maiden Name Pauline Hemsley

15. Birthplace MD.

16 (a) Informant Mr. John H. Rogers

(b) Address 3504 Howard Park Ave, Z-7

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/7/48 (month) (day) (year)

(c) Cemetery or crematory Wye Mills Epis. Ch.

Location WYE MILLS, MD.

18 (a) Funeral director Wm. T. Tucker & Sons

(b) Address Balto., MD.

MDC 6 1948 Baltimore Md. (Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1948, at 11 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 23 1948 to April 4 1948, and that I last saw h[illegible]y alive on April 4 1948.

Immediate cause of death: Respiratory Failure — Duration: 24 hours

Due to Cerebral Hemorrhage — 5 yrs

Due to Cerebral Hemorrhage — 72 hours

Due to Hypertensive cardio-vascular disease — 10 yrs

Other Conditions: Pneumonia, lobar, left, lower

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Millard T. Tralor Jr. M.D.

Address 3400 Woodbine Ave, Z7 Date signed 4/14/48

G61934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

X G61934 Registered No.

PRESS FIRMLY. WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: W. Balto Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and name of town)
(d) Street No. 2417 Braman Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) —
If yes, name country

3 (a) FULL NAME GEORGE JOHN GEBHARDT
3 (b) If veteran, name war WWI
3 (c) Social Security Account No 210-10-4625
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced MARRIED
6 (b) Name of husband or wife SARAH K. NEE KENNEDY
6 (c) If alive, give age years
7. Birth date of deceased mo., day, yr. SEPT 14, 1898
8. AGE: Years 49 Months 6 Days 20 If less than one day hr. min.
9. Birthplace BALTO., MD. (Town, county, and state)
10. Usual Occupation CREDIT MANAGER
11. Industry or business E. KAHN & CO.
FATHER 12. Name GEO. J. GEBHARDT
13. Birthplace UNKNOWN
MOTHER 14. Maiden Name ANNA BUSCHMAN
15. Birthplace MD.
16 (a) Informant MRS. SARAH K. GEBHARDT
(b) Address 2417 BRAMAN AVE
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/7/48 (month) (day) (year)
(c) Cemetery or crematory LORRAINE
Location BALTO CO. MD.
18 (a) Funeral director WM. A. TICKNER & SONS
(b) Address BALTO., MD.
19 (a) APR 5 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1948 at 9:45 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 3-15 1948 to 4-4 1948, and that I last saw h[illegible] alive on 4-4 1948.
Immediate cause of death CORONARY ARTERIOSCLEROSIS — Duration
Due to —
Due to —
Other Conditions PULMONARY INFARCTIONS & OLD MYOCARDIAL INFARCTIONS
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy [illegible] above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —
23. Signature Albert Gubitosa, M.D.
Address Wm. Baltimore General Hosp. Date signed 4/8/48

VS 153

X

G61935 BALTIMORE CITY HEALTH DEPARTMENT G61935
Registered No.

CERTIFICATE OF DEATH 1937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 23-2
(b) Street address
(c) Hospital or institution South Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1479 Patapsco St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander J Newman

3 (b) If veteran, name war Vo
3 (c) Social Security Account No. ?

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. DIVORCED

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/4/1867

8. AGE: Years 80 | Months 8 | Days 29 | If less than one day hr. min.

9. Birthplace BALTO, MD (Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER 12. Name JAMES NEWMAN
13. Birthplace IRELAND

MOTHER 14. Maiden Name MARGARET GILLESPIE
15. Birthplace CANADA

16 (a) Informant Miss REBECCA HENNESSY (NIECE)
(b) Address 1479 PATAPSCO ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/6/45 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location BALTO. MD

18 (a) Funeral director WM J. TURNER & SONS
(b) Address BALTO, MD

19 (a) APR 5 - 1945 (Date rec'd by registrar) (b) Interment for Williamsport MD

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2nd 1945, at 1:40 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Helfrich M.D.
Medical Examiner.
Date signed 4/3/45

VS 181

G61936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G61936 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland 12-5

(b) Street address 33rd & Celadon St.

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days

(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore 11, Md (If outside city or town limits, write RURAL and give town)

(d) Street No. 3149 Tilden Drive (If rural, give location) Ga. Ho. 11, Md.

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Clarence E. Pletzer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife GEORGIA.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 26, 1883

8. AGE: Years 62 yrs. Months 7 Days 11 If less than one day hr. min

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Brass Maker

11. Industry or business

FATHER

12. Name Not known -

13. Birthplace Not known -

MOTHER

14. Maiden Name Laura Kelly

15. Birthplace Baltimore

16 (a) Informant MR. REED E. PLETZER

(b) Address 3149 TILDEN DR.

17 (a) Burial (Burial, cremation, or removal)

(b) Date thereof 4/6/48 (month) (day) (year)

(c) Cemetery or crematory MEADOWRIDGE

Location HOWARD CO., MD.

18 (a) Funeral director WM. T. TICHNER & SONS

(b) Address Charles & Preston Sts. Baltimore, MD.

APR 10 1948 (Date) (Signature of registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1948, at 7:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 20 1948 to April 3 1948, and that I last saw him alive on April 2 1948.

Immediate cause of death: Congestive Heart Failure — Duration: 14 days

Due to Arteriosclerotic Heart Disease — 6 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?

(e) Means of injury

23. Signature John R. Smith, Jr.

Address Union Memorial Hospital Baltimore 11, Md. Date signed 4/5/48

VS 139

X

G61937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G61937 Registered No. 1310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3413 Gwynns Falls Park Way

(c) Hospital or institution: 15-8 ✓

(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓

(e) Length of stay in Baltimore (yrs., mos., or days) 86

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3413 Gwynns Falls Pkwy (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Fannie Grace Sheuton

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4 Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife James F. Sheuton (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19. 1861

8. AGE: Years 86 | Months 6 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and State)

10. Usual Occupation None. Housewife

11. Industry or business

FATHER 12. Name Levi Taylor

13. Birthplace Baltimore. Md.

MOTHER 14. Maiden Name Rebecca Eboaugh

15. Birthplace Baltimore Md.

16 (a) Informant Wm F. Sheuton

(b) Address 3417 N. Payson St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/6/48 (month) (day) (year)

(c) Cemetery or crematory MT. OLIVET

Location Balto. Md.

18 (a) Funeral director Wm T. Tickler & Sons

(b) Address Balto. Md.

19 APR 5 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1948 at 8.56 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Dec 15 1941 to Apr 3 1948 and that I last saw her alive on Apr 3 1948.

Immediate cause of death

Cardio-vascular-renal disease a hypertension — Duration ?

Due to Arteriosclerosis ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Charles L. Weaver M. D.

Address 42 Md. Ave. Balto. Date signed 4/4/48

VS 150

X

G61938

BALTIMORE CITY HEALTH DEPARTMENT ✓ G61938 Registered No.

CERTIFICATE OF DEATH 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd Calvert St. 27-12
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 324 Rosebank Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** MARTIN E. BOESSEL, SR.

3 (b) If veteran, name war? No

3 (c) Social Security Account No. -

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: FRIEDA E. BOESSEL

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr: 3-3-1874

8. AGE: Years: 74 | Months: 1 | Days: 0 | If less than one day: hr. min.

9. Birthplace Annapolis, Md (Town, county, and state)

10. Usual Occupation Pharmacist - (RET.)

11. Industry or business

FATHER
12. Name Christian Boesel
13. Birthplace GERMANY

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant MR. MARTIN E. BOESSEL JR.
(b) Address N 24 PENTRIDGE RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/6/48 (month, day) (year)
(c) Cemetery or ~~Crematory~~ LONDON PK
Location BALTO., MD.

18 (a) Funeral director WM. J. TICHNER & SONS
(b) Address BALTO MD.

APR 2 1948 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-3-48 19 . at 3:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-17- 1948. to 4-3-1948. and that I last saw HIM alive on 4-3-1948.

Immediate cause of death: Cerebral hemorrhage — Duration: 17 days

Due to Hypertension — ? years

Due to

Other Conditions Pneumonia — 5 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work?)
(e) Means of injury

23. Signature J. A. Gregory, Jr. M. D.
Address Union Memorial Hosp Date signed 4-3-48

VS 193

G61939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161c

G61939
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County York
(c) City or town Dover Pa R.D. 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Gross

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W	S

6 (b) Name of husband or wife — 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31 1948

8. AGE: Years | Months | Days | If less than one day: hr. min.
5

9. Birthplace York Co Pa
(Town, county, and state)

10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Edgar Gross
13. Birthplace York Co Pa

MOTHER
14. Maiden Name Ruth Robinson
15. Birthplace York Co Pa

16 (a) Informant Edgar Gross
(b) Address Hanover Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 6 1948 (month) (day) (year)
(c) Cemetery or crematory Evergreen Cem Dover Pa
Location

18 (a) Funeral director Wm. H. Hoke
(b) Address Dover Pa

19 (a) Date received APR 5 1948 (b) Registrar's signature Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1948, at 5 00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 3, 1948, to April 4, 1948, and that I last saw her alive on April 4, 1948.

Immediate cause of death Cardio-respiratory failure — Duration

Due to Myocardial failure, Congenital Heart Disease

Due to

Other Conditions 1) Jaundice, obstr.; ? intrahepatic
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Stanley A. Steinberg
Address Sinai Hospital Date signed 4/5/48

C61940

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93E

Registered No. C61940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1408 E. Madison St
(c) Hospital or institution: 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 E. Madison St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Edward Stanley

4-2-48

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	Col.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1870

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Airy Md (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Eben Stanley
13. Birthplace Airy Md

MOTHER
14. Maiden Name Mahaley Jackson
15. Birthplace Airy Md

16 (a) Informant Estella Stanley
(b) Address 527 N. Dallas St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 6 - 1948 (month) (day) (year)
(c) Cemetery or crematory Loudenbridge Md
Location Elroy O. Wilson
18 (a) Funeral director
(b) Address 1000 Broadway
19 (a) APR 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams Md (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1948 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 30 1948 to April 2 1948, and that I last saw h alive on April 2 1948.

Immediate cause of death
Bronchopneumonia
Due to Myocarditis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
Days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Albert L Lapsley
Address 622 N. Broadway Date signed 4/3/48

VS 189

X

C61941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. C61941

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1308 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lillie E. Everist

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
F.	W.	Widowed

6 (b) Name of husband John Everist

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11th 1861

8. AGE: Years	Months	Days	If less than one day: hr.	min.
86	11	23		

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name (Unknown) Fox
13. Birthplace Harford Co. Md

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Stephen P. Everist
(b) Address 2631 Robb st

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/7/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Morland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) APR 6 - 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4/1948 at 9:45 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Myocardial degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D. Medical Examiner.
Date signed

VS 151

C61942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

C61942
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 810 Beaumont Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 810 Beaumont Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilbur Tennyson Hartley

3 (b) If veteran, name war: no

3 (c) Social Security Account No: 216-10-9236

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Minna K. Hartley

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 7, 1875

8. AGE: Years: 73 Months: 2 Days: 27 If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Salesman - retired

11. Industry or business:

FATHER
12. Name: Phineas Hartley
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Deborah Cornthwaite
15. Birthplace: Maryland

16 (a) Informant: Mrs. Minna K. Hartley
(b) Address: 810 Beaumont Avenue

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 4/7/48 (month) (day) (year)
(c) Cemetery or crematory: Friends
Location: Baltimore, Maryland

18 (a) Funeral director: Wm. Cook, Inc.
(b) Address: 1217 St. Paul Street.

APR 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 'B3

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 4, 1948, at 11:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4 1947, to Apr. 4 1948 and that I last saw h/ alive on Apr. 4 1948

Immediate cause of death: Coronary Thrombosis — Duration: 1 day

Due to: Arteriosclerosis Heart Disease — Duration: yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Geo. Dawson M.D.
Address: 1202 Harford Ave. Date signed: 4/5/48

G61943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G61943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3025 Frederick Avenue
(c) Hospital or institution: 22-L
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 409 W. Pratt Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martha G. Liebman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Frank F. Liebman
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr Jan. 21, 1870

8. AGE: Years	Months	Days	If less than one day
78	2	13	hr. min

9. Birthplace Stuttgart, Germany (Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business

FATHER
12. Name Otto Greeninger
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Frank F. Liebman
(b) Address 3025 Frederick Avenue

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 4/7/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (Date received by Registrar) APR 6 1948 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1948 at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1948 to April 4 1948 and that I last saw h alive on April 4 1948.

Immediate cause of death: Acute Cardiac Dilatation — Duration: Few days
Due to Hypertensive Cardio-Vascular Disease
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank F. Liebman M. D.
Address 15 S. Eutaw St Date signed April 6 1948

X

G61944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G61944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address LAFAYETTE AND JOHN

(c) Hospital or institution:

WOMAN'S HOSPITAL 905

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Days

(e) Length of stay in Baltimore (yrs., mos., or days) 39 YRS

2. USUAL RESIDENCE OF DECEASED:

(a) State MARYLAND (b) County —

(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1130 HOMESTEAD ST
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MILDRED MARIE WATTS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband ~~or wife~~ SAMUEL W. WATTS

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) MAY 18, 1908

8. AGE: Years	Months	Days	If less than one day
39	10	17	hr. min.

9. Birthplace BALTIMORE — MARYLAND
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business HOME

FATHER

12. Name PETER BIRCH

13. Birthplace BALTIMORE MD

MOTHER

14. Maiden Name ANNA ?

15. Birthplace BALTIMORE MD

16 (a) Informant MILDRED WATTS

(b) Address 1130 HOMESTEAD ST.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/8/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Holy Redeemer

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 127 S. Paul St.

19 (a) Filed APR 8 1948 (b) Date received 1948 (By registrar)

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1948, at 6 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 28 1948 to April 6 1948, and that I last saw h. alive on April 5 1948.

Immediate cause of death

Cerebral Hemorrhage — Duration: 1 MIN

Due to Hypertensive Cardiovascular — Duration: +1 YR.

Due to Uremia.

Other Conditions Anemia, secondary

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Frank B. Agro Jr M. D.

Address Women's Hospital Date signed 4/8/48

VS 150

X

G61945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G61945 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 N. Carrollton Ave.
(c) Hospital or institution: 16-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 822 N. Carrollton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME AGNES COX

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	Colored	WIDOWED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1858

8. AGE: Years	Months	Days	If less than one day
90			hr. min.

9. Birthplace Howard Co., Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Samuel Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Mary ?
15. Birthplace Md.

16 (a) Informant Mrs. Mamie C. Fuller
(b) Address 1525 Que Street N. W. Washington, D. C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-7-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (d) APR 6 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 4 1948, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from APRIL 1, 1948 to APRIL 4, 1948, and that I last saw her alive on APRIL 1, 1948.

Immediate cause of death ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — Duration: 4 Months
Due to CEREBRAL ARTERIO-SCLEROSIS — Duration: 2
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas W. Harris M. D.
Address 172 W. Franklin St. Date signed 4-4-48

VS 150

661946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered 661946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5416 Reisterstown Road
(c) Hospital or institution: 28-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5416 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Fred Bohn

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret Bohn

6 (c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): July 3, 1874

8. AGE: Years: 73 | Months: 9 | Days: 0 | If less than one day: hr. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business: Balto. American Ins. Co.

FATHER
12. Name: John Fred Bohn Sr.
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Mrs. Margaret Bohn
(b) Address: 5416 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/ 6/ 1948 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Maryland

18 (a) Funeral director: Henry Sander & Sons, Inc.
(b) Address: North Ave & Broadway

APR 6 - 1948 (Date received by registrar) Huntington Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1948, at 1.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/28 1948 to 4/3 1948 and that I last saw [illegible] alive on 4/3 1948

Immediate cause of death: Bronchial Pneumonia — Duration: 7 days

Due to:

Due to:

Other Conditions: Arteriosclerosis — 10 yrs
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: none

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: X
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature H. A. Hearn M.D.
Address 3901 Garrison Blvd. Date signed 4/5/48

X

G61947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G61947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2708 N. CALVERT ST.
(c) Hospital or institution: 12-3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO., MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2708 N. CALVERT ST.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR M. MARRIOTT

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 15 1879

8. AGE: Years	Months	Days	If less than one day
68	9	19	hr. min.

9. Birthplace BALTO., MD. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name GEO. H. MARRIOTT
13. Birthplace BALTO. MD.

MOTHER 14. Maiden Name MARY V. GUIN
15 Birthplace BALTO. MD

16 (a) Informant Mrs. Frederick W. Farley
(b) Address 605 Fawn Ave

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/6/48 (month) (day) (year)
(c) Cemetery or crematory WOODLAWN
Location BALTO. CO. MD.

18 (a) Funeral director Wm. T. PICKERSONS
(b) Address BALTO., MD.

APR 6 - 1948 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1936 to APR 4 1948
and that I last saw him alive on Apr 3 1948.

Immediate cause of death	Duration
Coronary Thrombosis	15 min.
Due to Arteriosclerosis	Indefinite
Due to Coronary Sclerosis	Indefinite
Other Conditions Myocarditis	Indefinite

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify home, farm, etc.) While at work?
(e) Means of injury

23. Signature Nathaniel M Beck M. D.
Address 1002 23rd St Date signed Apr 5-48

G61948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G61948 ✓ Registered No.

126456

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 9-9
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 N Spring St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Waudby
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, ~~widowed~~, or ~~divorced~~: Married

6 (b) Name of husband or wife: William Waudby
6 (c) If alive, give age 2 years

7. Birth date of deceased mo., day, yr: 8-13-21

8. AGE: Years 26 | Months 7 | Days 23 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation unemployed
11. Industry or business

FATHER 12. Name Harry Schmidt
13. Birthplace Md.

MOTHER 14. Maiden Name Ida Wittel
15. Birthplace Md

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 8th 1948 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Frederick Road

18 (a) Funeral director Leo F. Cook
(b) Address 1701-03 N. Patterson Park ave

19 (a) Filed APR 6 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April - 5 1948 at 2.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-9- 1948 to 4-5- 1948 and that I last saw her alive on 4-5- 1948.

Immediate cause of death: Subdural and subarachnoid hemorrhage — Duration <1hr
Due to: Congenital intracranial aneurysm
Due to:
Other Conditions: H.C.-V.D. Patent ductus arteriosus, figated
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Victor A. McKusick M.D.
Address Johns Hopkins Hosp Date signed 4/5

96

VS 190 — 11

G61949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G61949
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1830 N. Port St
(c) Hospital or institution: 8-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1830. N. Port St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter R. Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~ Married

6 (b) Name of husband or wife Anna. M. Adams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 11th 1886

8. AGE: Years 61 | Months 6 | Days 27 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business Lumber broker & seal

FATHER
12. Name James. E. Adams
13. Birthplace Md

MOTHER
14. Maiden Name Mary F. Moore
15. Birthplace Md

16 (a) Informant Mrs Anna M. Adams
(b) Address 1830. N. Port St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 7th 1948 (month) (day) (year)
(c) Cemetery or crematory Lyartz
Location O'Donnel St Ext

18 (a) Funeral director Leo G. Cook
(b) Address 1701-03. N Patterson Park Ave

19 APR 6 - 1948 (Date rec'd by registrar) Huntington Williams Reg'r

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-7th 1948, at 9.15 P. M.

21. I certify that death occurred on the date above stated: that I attended deceased from 5-20-1919 to 4-7-1948, and that I last saw h— alive on 4-7-1948

Immediate cause of death: Cerebral hemorrhage — Duration: 5 hours

Due to Depression

Due to Hypertension Cardiovascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Fontaine M.D.
Address 23 E Lanvale St Date signed 4-8-48

VS 189

X

C61950

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13a

C61950 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 13-1
(b) Street address Cayuga & Dukeland
(c) Hospital or institution: Jno. Hopkins General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 825 Chauncey Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Allan ~~Thos~~ E Cohan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 6 8

8. AGE: Years	Months	Days	If less than one day: hr	min
49				

9. Birthplace Tunacock Va (Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business

FATHER — 12. Name	Louis
FATHER — 13. Birthplace	Russia
MOTHER — 14. Maiden Name	Mary
MOTHER — 15. Birthplace	Russia

16 (a) Informant Mary Cohan
(b) Address 825 Chauncey Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-6-48 (month) (day) (year)
(c) Cemetery or crematory Location: Hebrew Friendship
18 (a) Funeral director Jack Lewis Inc
(b) Address 2140 Eutaw Place
19 APR 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 June 1948 at 9:23 M

21. I certify that death occurred on the date above stated, that I attended deceased from 3/30 1948 to 4/4 1948.
and that I last saw ~~him~~ alive on 4/4 1948.

Immediate cause of death Cardiac Insufficiency

Due to Cerebral Hemorrhage

Due to Hypertension Encephalopathy Hypertensive F.D. Chronic

Other Conditions Azotemia - Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lester A. Hall M.D.
Address Jack Brothers Inc Hosp Date signed 4/5/48

VS .99

C61951

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

Registered No. C61951

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 15-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1736 No Eutaw St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Londow

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Jessie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr	min
86				

9. Birthplace Lith (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Abraga
13. Birthplace Lith

MOTHER
14. Maiden Name Bala
15. Birthplace Lith

16 (a) Informant Jessie Londow
(b) Address 1736 No Eutaw St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-6-48 (month) (day) (year)
(c) Cemetery or crematory Rozedale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

APR 6 - 1948 Huntington Williams Md
(Date received) (Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH APR. 5 1948, at 11:54 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from APR. 2 1948 to APR. 5 1948, and that I last saw him alive on APR. 5 1948.

Immediate cause of death HEART FAILURE — Duration

Due to ARTERIOSCLEROSIS AND HYPERTENSION

Due to

Other Conditions PROSTATIC HYPERTROPHY

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, in industrial place, in public place? (Specify) (While at work?)
(e) Means of injury

23. Signature I. Samuel Herman

Address Sinai Hospital Date signed 4-6-48.

VS 150

X

661952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95C

661952

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Mercy

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 926 N. Eaton St (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Cora B. Weaver

3 (b) If veteran, name war

3 (c) Social Security Account No. 211-12-9318

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Elsther Weaver

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 16, 1899

8. AGE: Years: 48 Months: 6 Days: 14 If less than one day: hr. min.

9. Birthplace: N. C. (Town, county, and state)

10. Usual Occupation: Housework

11. Industry or business

FATHER — 12. Name: Peter Marten

13. Birthplace: Unk.

MOTHER — 14. Maiden Name: Unknown

15. Birthplace: Unknown

16 (a) Informant: Esther Weaver

(b) Address: 926 N. Eaton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: April 6 - 48 (month) (day) (year)

(c) Cemetery or crematory: Mt. Auburn Cemetery

Location: Westport Balto. Md.

18 (a) Funeral director: George M. Gibson Sr.

(b) Address: 1735 Druid Hill Ave.

APR 6 - 1948 (Date received by registrar) (b) Huntingtown Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1948, at 7:32 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 20 1948 to April 3 1948, and that I last saw her alive on April 3 1948.

Immediate cause of death

Due to: Peripheral Vascular Collapse

Due to: Congestive Cardiac Decompensation

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Congestive Failure

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, industrial place, in public place? (Specify) While at work?

(e) Means of injury

23. Signature W. K. Schmitzberger M.D.

Address: Mercy

Date signed: 4-3-48

C61953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. C61953

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Laytons Lane

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1314 Hollins St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mrs Margaret E Kissing

3 (b) If veteran, name war

3 (c) Social Security Account No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife Harry

6 (c) If alive, give age years

7. Birth date of deceased mo. day yr 2-15-

8. **AGE:** Years 62 | Months 10 | Days 14 | If less than one day hr min

9. Birthplace (Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

APR 6 - 1948 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. **DATE OF DEATH** 4 April 1948 at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 April 1948 to 4 April 1948 and that I last saw h alive on 4 April 1948.

Immediate cause of death: Cardiac Insufficiency

Due to Cerebral Hemorrhage

Due to Arteriosclerosis

Other Conditions Arteriosclerotic C.V. Dis.

(Include pregnancy within 3 months of death)

Duration

Date of operation

Major findings of operation:

of autopsy: Above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Lester A. Dorsey M. D.

Address Mt Bayview Hosp Date signed 4/6/48

66 1954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 188

Registered No. 66 1954

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 Broad & Green
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3044 Hudson St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Walter A. Soth

3 (b) If veteran, name war: World War I.
3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elva J. Soth
6 (c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): Feb 21, 1892

8. **AGE:** Years: 56 | Months: 1 | Days: 13 | If less than one day: hr. min.

9. Birthplace: San Francisco, California (Town, county, and state)

10. Usual Occupation: Retired
11. Industry or business:

FATHER
12. Name: Philip E. Soth
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Ellen Welsh
15. Birthplace: Canada

16 (a) Informant: George Soth
(b) Address:

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: April 7 1948 (month) (day) (year)
(c) Cemetery or crematory: Lakewood
Location: Baltimore, Md.

18 (a) Funeral director: Frederick W. Cole
(b) Address: 1900 W. Lanvale St.

APR 6 1948 (Date received by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. **DATE OF DEATH** 4/4 1948, at 12:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/4 1948 to 4/4 1948, and that I last saw h[illegible] alive on 4/4 1948.

Immediate cause of death
Shock
Due to Ruptured intra abdominal
Due to Viscus
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes [illegible]
(a) Accident, suicide, or homicide
(b) Date of occurrence 4/4/48 at 11 A.M.
(c) Where did injury occur? Miller's, Balto, Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Farm (Specify type of place) While at work? Yes
(e) Means of injury: Falling down stairs by loss

23. **Signature** Dr. Fly Ellis, M. D.
Address [illegible] Date signed 4/6/48

For F. H. Davis, by Howard J. Madden, M.D.

G61955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. G61955

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp. M.C.V.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 742 W. Balto. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Frank Martin

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1901

8. AGE: Years	Months	Days	If less than one day
47	1	22	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name Purington Brown
13. Birthplace Baltimore

MOTHER
14. Maiden Name Virginia Bussey
15. Birthplace Virginia

16 (a) Informant Frank Martin
(b) Address 742 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (mo., day, yr.)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Road Westport

18 (a) Funeral director Frederick A. Cole
(b) Address 1200 W. Lombard St.

APR 6 - 1948 (Date received by registrar) (Signature of registrar)

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1948, at 6:20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection and Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Illuminating Gas.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-2-48 at ? A.M.
(b) Where did injury occur? 742 W. Balto. St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Four unlit gas jets, range.

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 4-3-48

G61956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V163#

G61956 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4503 Schley Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA Thomas

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 16. 1901

8. AGE: Years 47 | Months 46 | Days 12 | 19 | If less than one day hr. min.

9. Birthplace Plymouth Mass (Town, county, and state)

10. Usual Occupation Library Clerk

11. Industry or business

FATHER 12. Name Geo H. Thomas

13. Birthplace Balto.

MOTHER 14. Maiden Name Matilda Martin

15. Birthplace White Hall L.I.

16 (a) Informant Geo H. Thomas

(b) Address 4503 Schley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/48 (month) (day) (year)

(c) Cemetery or crematory Emmanuel

Location Linden Lane

18 (a) Funeral director L. Heemann & Son

(b) Address 6067 Hartford Ave

APR 6 - 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4/48 19 , at 1:35 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH asphyxiation due to illuminating gas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 4/4/48 at 11:00 A M.

(b) Where did injury occur? 4503 Schley

(c) Did injury occur at home, on farm, industrial place or public place? Home While at work? No

Means of injury Turned on gas burners

23. Signature John R Davis M.D. Medical Examiner.

Date signed 4/4/48

C61957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C61957

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 8-3
(b) Street address
(c) Hospital or institution: Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2735 Boyle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mare M Weiss

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife Karl Weiss

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1887

8. AGE: Years 61 | Months 2 | Days 26 | If less than one day hr. min.

9. Birthplace Germany (Town, county and state)

10. Usual Occupation House Work

11. Industry or business At Home.

FATHER
12. Name ? Rutsch
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Mellber
15. Birthplace Germany.

16 (a) Informant Karl Weiss (Husband)
(b) Address 2735 Boyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof apr 7, 48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Belair Rd.

18 (a) Funeral director Charles L. Zeiler
(b) Address 901 E. Cold Spring Lane

19 Apr 6 - 1948 (Date rec'd by Registrar) (b) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4th 1948, at 12:20 M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio - Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G. Stelloch M.D. Medical Examiner

Date signed Apr 5, 48

VS 191

G61958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G61958

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) W

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 6902 Homeway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W Phillips

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Agnes M. Phillips
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 1, 1907

8. AGE: Years	Months	Days	If less than one day
40	4	4	hr. min.

9. Birthplace Richmond, Va. (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Wm. R. Phillips
13. Birthplace Va.

MOTHER
14. Maiden Name Rose E. Gifford
15. Birthplace Va.

16 (a) Informant Agnes M. Phillips
(b) Address 6902 Homeway, Dundalk

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 8, 1948 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Blvd.

18 (a) Funeral director Roland L. Fisher
(b) Address 2112 Dundalk Ave.

19 (a) APR 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 April 1948, at 9 15 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Rammer Jr. M.D. Medical Examiner.
Date signed April 1948

G61959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

Registered No. G61959

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 611 Glenwood Avenue
(c) Hospital or institution: 27-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 611 Glenwood Avenue (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME GEORGE B HEIM

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: YES

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: ALMA C. HEIM
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 1, 1869

8. AGE: Years 78 | Months 5 | Days 4 | If less than one day: hr. min.

9. Birthplace: BALTO. MD. (Town, county, and state)

10. Usual Occupation: RETIRED - TIRE INSPTR
11. Industry or business: P.R.R.

FATHER
12. Name: FREDERICK HEIM
13. Birthplace: MD.

MOTHER
14. Maiden Name: REGETTA SMITH
15. Birthplace: MD.

16 (a) Informant: ALMA C. HEIM
(b) Address: 611 GLENWOOD AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/48 (month) (day) (year)
(c) Cemetery or crematory: DRUID RIDGE
Location: TOWSON, MD.

18 (a) Funeral director: WM. T. TICKNER & SONS
(b) Address: BALTO., MD.

19 (a) APR 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/5/48 19 . 1230P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
a Strangulation

Due to

Other Conditions Mental Depression

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4/5/48 at 11A M.
(b) Where did injury occur? 611 Glenwood Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
Means of injury Illuminating Gas

23. Signature John R. Walsh M.D. Medical Examiner.
Date signed 4/6/48

VS 181

G61960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G61960

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 142 W. LANVALE ST.
(c) Hospital or institution: 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 142 W. LANVALE ST
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME KATHARINE LENNARD HUTCHINS

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Sing 6

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
Over 50			hr. min.

9. Birthplace BALTO., MD.
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name LEWIS HERMAN HUTCHINS
13. Birthplace MyLADYS MANOR, BALTO Co., MD.

MOTHER
14. Maiden Name KATHARINE LENNARD
15. Birthplace BALTO

16 (a) Informant Miss MARY HUTCHINS
(b) Address 142 W. LANVALE ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/7/48 (month) (day) (year)
(c) Cemetery ~~cemetery~~ DRUID RIDGE
Location RIVERDALE MD

18 (a) Funeral director WM. T. MOTHER & SONS
(b) Address BALTO, MD

19 (a) APR 6 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1948 at 2:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1948 to April 5, 1948 and that I last saw her alive on April 3 1948.

Immediate cause of death Arteriosclerotic Cardio-vascular Disease — Duration: Few years

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. A. Swoman M.D.
Address 1109 N. Calvert St. Date signed 4/5/48

VS 150

G61961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. G61961

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5231 KEISTERSTOWN RD.

(c) Hospital or institution: 27-18

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County —

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 5231 KEISTERSTOWN RD. (If rural give location)

(e) Citizen of foreign country? — (Yes or No) If yes, name country —

3 (a) FULL NAME H. GRANT BLACKSTEN

3 (b) If veteran, name war NONE

3 (c) Social Security Account No. 213-10-1569

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife BERTHA I. BLACKSTEN

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) NOV. 9, 1868

8. AGE: Years 79 | Months 4 | Days 24 | If less than one day: hr. — min.

9. Birthplace FREDERICK Co. MD. (Town, county and state)

10. Usual Occupation RETIRED - BALTO TRANSIT

11. Industry or business

FATHER 12. Name JOHN BLACKSTEN

13. Birthplace MD.

MOTHER 14. Maiden Name LIZA

15. Birthplace MD

16 (a) Informant MISS EVELYN BLACKSTEN

(b) Address 5231 KEISTERSTOWN RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/6/48 (Month) (day) (year)

(c) Cemetery or crematory DRUID RIDGE

Location PIKESVILLE, MD

18 (a) Funeral director WM. J. TICHNER & SONS

(b) Address BALTO Embalmer for Baltimore, Md.

19 (a) APR 6 - 1948 (Date received by reg.) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/3 1948, at 6 ½ PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 26 1948 to April 3 1948. and that I last saw h — alive on April 3 1948.

Immediate cause of death: Carcinoma Pancreas — Duration: 1

Due to Myocardiopathy Chronic Arterial Nephritis — 1

Due to —

Other Conditions Hypostatic Congestion — 2 days

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at — M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury —

(f) Signature [illegible] Address [illegible] Date signed 4/6/48

X

VS 150

C61962
410821

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 48a

Registered No. C61962

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 26-10
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 9201 Eichombard, St., (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country — — —

3 (a) FULL NAME George, Amelia

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: (Charles) George Sr.

6 (c) If alive, give age 68 years

7. Birth date of deceased mo., day, yr 2-27-87

8. AGE: Years 61 | Months 1 | Days 8 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name August Lahman
13. Birthplace Md.

MOTHER
14. Maiden Name Louise Reichert
15. Birthplace Md.

16 (a) Informant Recorder
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-8-48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Ext.

18 (a) Funeral director Lilly & Zeiler Inc
(b) Address 403 S. Wolfe St. 31

19 (a) APR 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/5 1948 at 5-30 AM 2nd 1 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24 1948, to 4/5 1948, and that I last saw her alive on 4/5 1948.

Immediate cause of death Heart failure

Due to Coronary Thrombosis

Due to unknown

Other Conditions Carcinoma of the cervix (Include pregnancy within 3 months of death)

Date of operation 4/2/48

Major findings of operation: Extensive carcinoma of cervix

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard Johns Pancoast M.D.

Address J.H.H. Date signed 4-8-48

X

C61963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. C61963

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3820 Bonner Road
(c) Hospital or institution: 15-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3820 Bonner Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anne M. Ferguson

3 (b) If veteran, name war ---

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Robert Ferguson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1874

8. AGE: Years	Months	Days	If less than one day
74	1	0	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John J. Myers
13. Birthplace Germany

MOTHER
14. Maiden Name Mary E. Dunn
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Rose E. Myers
(b) Address 3820 Bonner Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 8, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave.

1948 APR 6 - (Date rec'd by registrar) Huntington Williamsport, Md. Registrar

MEDICAL CERTIFICATION

6.45

20. DATE OF DEATH April 5, 1948, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 2 1948 to Apr 5 1948 and that I last saw her alive on Apr 4 1948

Immediate cause of death: Cerebral Hemorrhage + Paralysis — Duration: 3 days
Due to: advanced arterio sclerosis — ?
Due to: Hypertension — ?
Other conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter S. Hublett, M. D.
Address 220 Harrison Blvd. Date signed Apr 6/48

VS 150

C61964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1462

Registered No. C61964

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 8-3
(c) Hospital or institution Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 N. Bucker Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Berma R. Burnacker

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Walter H. Burnacker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jany 25 1899

8. AGE: Years 49 | Months 2 | Days 11 | If less than one day: hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation — housewife

11. Industry or business

FATHER
12. Name Wm. Reichelt
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary Bollinger
15. Birthplace Balto.

16 (a) Informant Lilly Binnsteiger
(b) Address 1610 E. 32 St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 8/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Balto. Co. Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) APR 6 - 1948 (Date rec'd by registrar) (b) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1948, at 2:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 14 1948, to 5 April 1948, and that I last saw h ER alive on 5 April 1948.

Immediate cause of death: Metastatic Carcinoma of Stomach — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. C. Cranmer M. D.
Address Md. Gen'l Hosp Date signed 5 Apr 48

VS 199

X

G61965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G61965

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Md. Gen. Hospital
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 Shadyside Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME John W. Deem

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Amelia Schuhler

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Aug 17, 1869

8. AGE: Years	Months	Days	If less than one day
78	7	19	hr min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name August Deem
13. Birthplace Md.

MOTHER
14. Maiden Name Caroline Hertenstein
15. Birthplace Alsace Lorraine

16 (a) Informant Miriam Deem
(b) Address 1501 Shadyside Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 7, 48 (month) (day) (year)
(c) Cemetery or crematory Oakland Cem. Location 7225 Eastern ave.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 4940 Eastern Place

19 APR 6 - 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1948. at 12 25 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 20 1948. to April 5 1948. and that I last saw him alive on April 4 1948.

Immediate cause of death	Duration
Cardiac failure	1 day.
Due to Arteriosclerotic Heart Disease	? years
Due to	
Other Conditions Intestinal Diverticulosis Ventral hernia	? years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred H. Deem M. D.
Address Maryland Gen'l Hosp. Date signed 4/5/48

VS 150

X

Dr. Weisman

661966

3900 Dorchester Rd

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 661966

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 711 Walnut Ave

(c) Hospital or institution: 284

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 711 Walnut Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Roy Jr Ingram

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr Oct 20 - 1895

8. AGE: Years 52 | Months 5 | Days 16 | If less than one day hr min

9. Birthplace Laurel Md (Town, county and state)

10. Usual Occupation Vender Machine Mechanic

11. Industry or business

FATHER 12. Name John R Ingram

13. Birthplace Laurel Maryland

MOTHER 14. Maiden Name Evelyn Nichols

15. Birthplace Laurel Md

16 (a) Informant Mrs Violet Graham

(b) Address 1655 N. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 7 1948 (months) (day) (year)

(c) Cemetery or crematory Western Cemetery Location Baltimore

18 (a) Funeral director Jeannie Cook Syfer

(b) Address 1600 N. North Ave

19 (a) APR 6 - 1948 (b) Registrar

Filed by Registrar Huntington Williams, M.D.

VS (S)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1948 at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7, 1947 to April 4 1948 and that I last saw him alive on March 28, 1948

Immediate cause of death: Coronary Thrombosis — Duration ?

Due to Cardiac insufficiency

Due to

Other Conditions Chronic Nephritis Hypertension grade III

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Samuel Weisman M.D.

Address 3900 Dorchester Rd Date signed 4/5/48

X

661967

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. 661967

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1306 John street
(c) Hospital or institution: 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED: ----
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 John street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME MARY E. BATES

3 (b) If veteran, name war -----
3 (c) Social Security Account No. -----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	Widow

6 (b) Name of husband or wife James Bates
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) May 4, 1858

8. AGE: Years	Months	Days	If less than one day
89	11	1	hr. ____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name William Morris
13. Birthplace Manchester, England

MOTHER
14. Maiden Name Julia McDonald
15. Birthplace Ireland

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans & Son, Inc.
(b) Address 118 W. Mt. Royal Ave

19 (a) Apr. 6 1948 Huntington Williams MD
(b) Signature of [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 19 48 at ____ M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16 1948 to 4-5 1948, and that I last saw h alive on 4-5 1948.

Immediate cause of death: Cardiac failure, Bronchopneumonia

Due to

Due to

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 3400 Kelso Rd Date signed 4/5/48

VS 150

G61968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

Registered No. G61968

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 420 S Madeira St.

(c) Hospital or institution: Bolt 21. 1-5

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0

(e) Length of stay in Baltimore (yrs., mos., or days 47 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County —

(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)

(d) Street No. 420 S Madeira St (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Cecelia Frank

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Geny Frank

6 (c) If alive, give age . years

7. Birth date of deceased (mo., day, yr.) Oct 19, 1898

8. AGE: Years 49. | Months 5 | Days 12-17 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Housework

FATHER — 12. Name James Lisiki

13. Birthplace Poland.

MOTHER — 14. Maiden Name Josephine Lisiki

15. Birthplace Poland.

16 (a) Informant Mr Geny Frank

(b) Address 420 S Madeira St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-8-48 (month) (day) (year)

(c) Cemetery ~~co-cemetery~~ St Stanislaus Location Baltimore Md

18 (a) Funeral director George A Weber

(b) Address 705 South Ann st

19 APR 6 - 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1948, at ? AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 24 19 48 to March 24 19 48 and that I last saw h[illegible] alive on March 24 19 48.

Immediate cause of death: Cardiac tamponade, (a) Ruptured heart aneurism (medical opinion)

Due to

Due to

Other Conditions Calyper's Anemia Chronic alcoholism

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
6 mo.
40 yrs.
10 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature David Bachrach M. D.

Address David Hess + Hays Date signed 4/5/48

VS 15a

Howard J. Andersen, M.D. 92C

G61969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G61969

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Linden Ave & Madison St

(c) Hospital or institution: Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 8023 Durnall Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Agnes Andrews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan 6, 1884

8. AGE: Years	Months	Days	If less than one day
64	-	9	hr min

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Jacob ? Stolofsky

13. Birthplace ?

MOTHER

14. Maiden Name ?

15. Birthplace ?

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-9-48 (month) (day) (year)

(c) Cemetery or ~~Crematory~~ Sacred Heart

Location Baltimore Md.

18 (a) Funeral director George A Weber

(b) Address 706 ~~Lexington~~ Huntington Ave Baltimore, Md

19 APR 6 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1948, at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1948, to April 5 1948, and that I last saw her alive on April 5 1948

Immediate cause of death Cardiac Respiratory failure — Duration

Due to Rural vascular accident

Due to Hypertensive cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature O. Jones Hunt

Address Md. Gen. Hosp Date signed 4/5/48 M.D.

VS 150

061970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No. 061970

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1519 Division Street
(c) Hospital or institution: Provident Hospital 16-03
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 831 N. Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dora Lee McLaughlin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/28/43

8. AGE: Years	Months	Days	If less than one day
5	2	5/6	hr. min.

9. Birthplace Clio, S.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Mamie McLaughlin
15. Birthplace

16 (a) Informant Mamie McLaughlin
(b) Address 1519 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date then April 9-1948 (month) (day) (year)
(c) Cemetery or crematory New Zion Cem.
Location Marlboro So. Car.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1900 Bentley ave

19 (a) APR 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1948 at 6.35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 1947, to 4/3 1948.
and that I last saw h[illegible] alive on 4/3 1948.

Immediate cause of death Hypertension
Secondary Shock
Due to 1st 2nd 3rd degree burns over 3/4 in body
Due to Accident
Other Conditions Paralytic Ileus

(Include pregnancy within 3 months of death)
Date of operation 1/5/48
Major findings of operation: Pinch graft of skin
of autopsy:

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: N/A
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 12/2/47 at ? M
(c) Where did injury occur? 831 N. Fulton Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Burns with matches ignited clothing

23. Signature Marcus W. Mayo Sr
Address Provident Hospital Date signed 4/5/48

VS 150 To be approved by Chief Medical Examiner or Deputy
for H. H. Hamilton M.D.
Howard J. Malkin, M.D.

C61971

HEALTH DEPARTMENT—CITY OF BALTIMORE

C61971

V83a

CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE (No. 628 St. Mary's St., 17-1 Ward)*

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Alonzo Stickpard

If U.S. Veteran specify WAR

(a) Residence: No. 628 St. Mary's St., — Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male | 4. Color or Race Col. | 5. Single, Married, Widowed, or Divorced (write the word) Widower

5a. If married, widowed, or divorced HUSBAND of (or WIFE of) Carrie Stickpard

6. DATE OF BIRTH (month, day, year) 1881

7. AGE: Years 67 | Months — | Days — | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Labourer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —

10. Date deceased last worked at this occupation (month and year) — | 11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) So. Carolina

FATHER

13. NAME —

14. BIRTHPLACE (city or town) (State or country) —

MOTHER

15. MAIDEN NAME —

16. BIRTHPLACE (city or town) (State or country) —

17. INFORMANT Celvia Young

(Address) 628 St. Mary's

18. BURIAL, CREMATION, OR REMOVAL

Place Mt. Auburn Cem Date 4-8-48 19

19. UNDERTAKER Mrs. Frances A. Hemsley

(Address) 576 W. Biddle St.

20. REC'D APR 6 - 1948 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Apr. 5 1948

22. I HEREBY CERTIFY, That I attended deceased from ..., 19.. to ..., 19..

I last saw him alive on Apr 3 1948 Death is said to have occurred on the date stated above, at ... m.

The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage — Date of onset

Other contributory causes of importance:

Was an operation performed? no Date of

For what disease or injury? —

What test confirmed diagnosis? — Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19..

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no If so, specify

(Signed) Hank B. Wagner M. D.

(Address) 2027 Calvert

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66 1972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 66 1972

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 13-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 707 W. 33rd St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: HENRY WILLIAM KAZMIERSKI

3 (b) If veteran, name war: WW I
3 (c) Social Security Account No.: ?

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ferol Palmer Kazmierski
6 (c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): Dec. 2, 1892

8. AGE: Years: 55 | Months: 4 | Days: 1 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Foreman
11. Industry or business:

FATHER
12. Name: Jacob Kazmierski
13. Birthplace: Poland

MOTHER
14. Maiden Name: Christine Nichols
15. Birthplace: Poland

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/48 (month) (day) (year)
(c) Cemetery or crematory: Holy Cross Cem.
Location: Annapolis Blvd.

18 (a) Funeral director: Thos. F. Dill
(b) Address: 1601 E. Fort Ave

19 (a) APR 6 - 1948 Huntington Williams, M.D.
(b) Filed by registrar: APR 6 1948

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3 1948, at 8:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 31 1948 to Apr. 3 1948, and that I last saw him alive on Apr. 3 1948.

Immediate cause of death: Subdural hematoma of temporal region, left, cause unknown — Duration:

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: 3/31/48

Major findings of operation: Subdural hematoma

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: Accident
(b) Date of occurrence: 3-31-48 at 3:30 P M
(c) Where did injury occur? 707 W. 33rd St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify) While at work? no
(e) Means of injury: Fell down stairs Inside

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon
Address: Clinical Director Date signed 4/6/48
For Wm. H. Kemp, Jr. by Howard T. Madden, M. D.

661973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 180

Registered No. 661973

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 Bergenite St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Augustus (William) Rusk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 28, 1887

8. AGE: Years	Months	Days	If less than one day: hr.	min.
60	7	8		

9. Birthplace Pennsylvania (Town, county and state)

10. Usual Occupation Retired U.S. Navy

11. Industry or business

FATHER
12. Name August C. Rusk
13. Birthplace Wilkes Barre Pa.

MOTHER
14. Maiden Name Jessie Skelton
15. Birthplace Sweet Arrow, Pa.

16 (a) Informant Foy Funeral Home
(b) Address Eastville, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-8-48 (month) (day) (year)

(c) Cemetery or crematory Johnson Cemetery
Location Eastville, Virginia

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St [illegible]

19 4-6-48 (b) [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1948, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/5 1948 to 4/6 1948, and that I last saw him alive on 4/6 1948.

Immediate cause of death
Shock & Toxemia
Due to Extensive 1st & 2nd Degree Burns
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 5/1
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 5 April 48 at M
(c) Where did injury occur? Balto. Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work?
(e) Means of injury fire

23. Signature Frank A. Foran M.D.
Address Mercy Hosp Date signed 4/6/48

To be approved by Medical Examiner OK HJM X

G61974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. 661974

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Wicomico Co
(c) City or town Salisbury (If outside city or town limits, write RURAL and give town)
(d) Street No. 313 Light St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Steffens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: X

6 (b) Name of husband or wife: Late Joseph

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr): [illegible] 1874

8. AGE: Years 73 | Months 11 | Days | If less than one day: hr. min.

9. Birthplace Chincoteague Island Va (Town, county, and state)

10. Usual Occupation Home, wife

11. Industry or business at Home

MOTHER / FATHER

12. Name John Russell

13. Birthplace Chincoteague Island Va

14. Maiden Name Charlotte Sharpley

15. Birthplace Chincoteague Island Va

16 (a) Informant Mrs. J. Walter Smith

(b) Address Easton Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-9-48 (month) (day) (year)

(c) Cemetery or crematory Wicomico Memorial

Location Salisbury Md

18 (a) Funeral director Mr. & Mrs. John W. Lanfel

(b) Address 511 Edmondson Ave

19 APR 6 - 1948 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1948, at 5:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-31 1948 to 4-6 1948, and that I last saw her alive on 4-5 1948.

Immediate cause of death: Metastatic carcinoma — Duration: ?

Due to Perforation of uterus — Duration: ?

Due to Adenocarcinoma of uterus — Duration: ?

Due to

Other Conditions Pyometra

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: Cancer of uterus

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theodore Tardesh

Address University Hosp Date signed 4-M 6-D 48

VS 153

X

G61975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1604

G61975
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Myers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Baby

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr 4/2/48

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace Gettysburg Md. PA.
(Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER
12. Name Arvel Myers
13. Birthplace Md.

MOTHER
14. Maiden Name Minnie Stonesifer
15. Birthplace Md.

16 (a) Informant Arvel Myers
(b) Address Westminster, Md R.D. 1

17 (a) Removal for Burial (b) Date thereof 4/8/48
(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory Methodist Cem.
Location Union Mills, Md.

18 (a) Funeral director P. W. Littlestown
(b) Address Littlestown, Pa. R.A. Leib

19 APR 7 - 1948 (b) Registered

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-6 1948 at 5:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-5 1948 to 4-6 1948 and that I last saw h alive on 4/6 1948

Immediate cause of death Cardiac & Respiratory failure due Probably to a Subdural Hemorrhage

Due to

Due to Cere. Syphilis treated

Other Conditions Edema

Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. Pugsley M.D.

Address University Hosp Date signed 4/6/48

VS 150

G61976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G61976

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1226 E. Madison St.
(c) Hospital or institution: 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1226 E. Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Florence Ellis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C.	Widowed

6 (b) Name of husband or wife George
6 (c) If alive, give age 0 years

7. Birth date of deceased (mo., day, yr.) MAR. 6. 1894

8. AGE: Years	Months	Days	If less than one day
54	-	29	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ?
13. Birthplace Md

MOTHER
14. Maiden Name Selina Fries
15. Birthplace Md

16 (a) Informant Violetta Ross
(b) Address 1226 E. Madison St

17 (a) Burial (b) Date thereof 4-7-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County, Md.

18 (a) Funeral director Joseph E. Locke
(b) Address 1364 N. Central Ave

1948 4-7-1948 Huntington Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-4 1948 at 6:13 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 12th 1948, to Apl 4th 1948 and that I last saw h[illegible] alive on Apl 4th 1948.

Immediate cause of death Cerebral hemorrhage — Duration 2 days

Due to Myocarditis

Due to Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Alfred A. Lefevre M. D.
Address 822 N. Broadway Date signed 4/7/48

VS 150

G61977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. G61977

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Green & Lombard St

(c) Hospital or institution: UMM Hospital 14-1

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1324 Mulberry Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cadmus R. Pfister

3 (b) If veteran, name war

3 (c) Social Security Account No. 247-01-6032

4. Sex	5. Color or race	6 (a) ~~Single, married,~~ widowed, or ~~divorced~~
M	W	Widowed

6 (b) Name of ~~husband or~~ wife Sadie Pfister

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec 22nd 1879

8. AGE: Years	Months	Days	If less than one day
68	3	13th	hr min.

9. Birthplace Richmond Va. (Town, county, and state)

10. Usual Occupation Shoe Cutter

11. Industry or business Regent & Ball

FATHER

12. Name (Unknown) Pfister

13. Birthplace Va.

MOTHER

14. Maiden Name "

15. Birthplace Va.

16 (a) Informant Chas. Pfister (Son)

(b) Address 1504 Mulberry St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/10/48 (month) (day) (year)

(c) ~~Cemetery or crematory~~ Mt. Carmel

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

19 APR 7 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-5 1948 at 6 60 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-3 1948 to 4-5 1948 and that I last saw h~~er~~ alive on 4-5 1948.

Immediate cause of death Cardiac failure

Due to pneumonia

Due to probably accidental vascular accident.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

Duration

663978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 663978

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1814 E. Balto St.
(c) Hospital or institution: 6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL ~~and give town~~)
(d) Street No. 1814 E Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie Saunders

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband ~~or wife~~: Benjamin F. Saunders

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30th 1894

8. AGE: Years 53 | Months 10 | Days 5 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name William Love
13. Birthplace Md.

MOTHER
14. Maiden Name Mollie Williams
15. Birthplace Md.

16 (a) Informant Benjamin Saunders
(b) Address 814 E. Balto St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/8/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location East Balto. St. Extended

18 (a) Funeral director William Cook Inc.
(b) Address 427 St. Paul St.

19 (a) APR 7 - 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5th 1948, at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1948 to April 5 1948 and that I last saw h alive on April 5 1948

Immediate cause of death (Carcinoma) C. A. Bowel — Duration 3 yrs

Due to —

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marcus D. Shields M.D.
Address 1431 Mendelson Date signed 4-5-48

V S 150

C61979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C61979

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2400 Arunah Ave
(c) Hospital or institution: 16-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2400 Arunah Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John F. Paul

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-01-8636

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Minnie M

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. March 22 1877

8. AGE: Years 71 | Months 0 | Days 14 | If less than one day: hr. 16 min. —

9. Birthplace Baltimore Co. Md. (Town, county, and state)

10. Usual Occupation Contractor

11. Industry or business Retired

FATHER
12. Name Arunah K. Paul
13. Birthplace Balto Co Md

MOTHER
14. Maiden Name Martha J. Kahn
15. Birthplace Baltimore Co. Md

16 (a) Informant Minnie Paul
(b) Address 2400 Arunah Ave

17. (a) Burial, cremation, or removal (b) Date thereof April 9 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Fulton Funeral Co
(b) Address 1217 Eutaw St

APR 7 - 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1948, at 7:4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-23 1944 to 3-27 1948 and that I last saw h in alive on 3-27- 1948.

Immediate cause of death	Duration
Coronary Sclerosis	1945
Cerebral Sclerosis	1944
Due to general arterio Sclerosis	1944
Due to Chronic myocardial insufficiency	1947
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. G. Wilkinson M. D.
Address 2730 Eutaw Pl. Date signed 4/6/48

661980

BALTIMORE CITY HEALTH DEPARTMENT

EL 118064

CERTIFICATE OF DEATH 129

Registered No. 661980

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospital 4-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1323 Wirton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary R. Kidd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 1, 1882

8. AGE: Years	Months	Days	If less than one day
66	4	5	hr. min

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Peter J. Garney
13. Birthplace Ireland

MOTHER
14. Maiden Name Katherine Crane
15. Birthplace Maryland

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, ~~cremation or removal~~) (b) Date thereof 4/9/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) APR 7 - 1948 (Date received by registrar) Huntington Williams, M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1948, at 6- A. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1948 to April 6 1948, and that I last saw her alive on April 6 1948.

Immediate cause of death	Duration
Generalized Peritonitis	24 hr
Due to Rupture of bladder ulcer	24 hr
Due to Chronic, severe Cystitis	4 yrs
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Peritonitis, cystitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature William M. Straight

Address BCH Date signed 4/6/48

X

C61981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C61981

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd + Calvert 12-5

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1720 St. Paul St., Balto (If rural give location)

(e) Citizen of foreign country? (Yes or No) No

If yes, name country

3 (a) FULL NAME Mrs. Jeanie S. Brockway

3 (b) If veteran, name war

3 (c) Social Security Account No. 492-26-5569

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Bert Brockway

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) June 29-1879

8. AGE: Years 69 | Months 2 | Days 10 | If less than one day hr min

9. Birthplace Missouri (Town, county, and state)

10. Usual Occupation Childs' Nurse

11. Industry or business

FATHER 12. Name Henry Clay Munger

13. Birthplace Vermont

MOTHER 14. Maiden Name Mary Jane Sheppard

15. Birthplace New York

16 (a) Informant Mrs. Edna Tyler

(b) Address 1720 St. Paul St., City

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof April 8-45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park. Location Baltimore Md

18 (a) Funeral director Ellsworth Armacost

(b) Address 4204 Ridgewood Ave.

19 (a) Huntington Williams, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1945 at 12 02 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from April 4 1945 to Apr. 6 1945. and that I last saw her alive on April 5 1945

Immediate cause of death: Cardio respiratory Collapse — Duration

Due to Cerebrovascular Accident

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place) While at work?

(e) Means of injury

23. Signature John Kellogg, M.D. M.D.

Address Union Memorial Hospital Date signed 4/6/45

VS 150

661982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 661982

1700

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hammond Ferry Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Donovon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Estelle Lewis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1876

8. AGE: Years 71 | Months 11 | Days 19 | If less than one day hr. min.

9. Birthplace Vermont
(Town, county, and state)

10. Usual Occupation Painting Foreman

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace —

MOTHER
14. Maiden Name Unknown
15. Birthplace —

16 (a) Informant: Mrs Estelle Donovon
(b) Address Hammond Ferry rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-8-48 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet
Location Baltimore, Md

18 (a) Funeral director Georgia Farley
(b) Address Fulton Ave & Fayette St.

19 (Date rec'd by registrar) APR 7 - 1948 Huntington Williams, M.D.

VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1948, at 8:45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Crushed Skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 5 1948 at 8:45 P.M.
(b) Where did injury occur? Hammond Ferry Rd. & Nursery Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Intersection While at work? No
(d) Means of injury? H.B.C. Fun driver

23. Signature Carl L. Pryor M.D.
Medical Examiner
Date signed 4/6/48

C61983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46 B

Registered No. C61983

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 28-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4111 Cathland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ISAAC FEODER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mollie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
74				

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Merdecai
13. Birthplace Russia

MOTHER
14. Maiden Name Esther
15. Birthplace Russia

16 (a) Informant Mollie Fedder
(b) Address 4111 Cathland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-7-48 (month) (day) (year)
(c) Cemetery or Crematory Rosedale
Location Philadelphia Rd + Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 APR 7 1948 (Date rec'd by local registrar) (Huntington Williamsport Md)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1948 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1, 1948 to April 7 1948 and that I last saw him alive on April 7 1948.

Immediate cause of death: Carcinomatosis — Duration: over

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which) While at work)
(e) Means of injury

23. Signature Allen J. Wolinsky M. D.
Address Sinai Hosp Date signed 4-7-48

VS 180

G61987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 131a

Registered No. G61987

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type or correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 631 N. Lakewood Ave.
(c) Hospital or institution: 7-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 631 N. Lakewood Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Elizabeth Kroll

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

(b) Name of husband or ~~wife~~ John Kroll
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1884

8. AGE: Years	Months	Days	If less than one day
64	2	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Frank Semmler
13. Birthplace Germany

MOTHER
14. Maiden Name Anna E. Grunewald
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Anna Spicer - daughter
(b) Address 631 N. Lakewood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/1948 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Baltimore
Location North Ave. & Rose St. Balto. Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 APR 7 - 1948 Registered by Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1948, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 17 1947 to Apr. 7 1948.
and that I last saw h alive on Apr. 7 1948.

Immediate cause of death: Hypertensive Cardio-Vascular renal disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. J. Schmuck, M.D.
Address 701 N. Kenwood Ave. Date signed 4/7/48

X

VS 189

G61985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (1937)

Registered No. G61985

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6-2
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hours
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 404 N. Glover St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Joseph Kraus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Amanda (nee Schaaf)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 15, 1898

8. AGE: Years	Months	Days	If less than one day
49	6	19	hr min

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Rice's Bakery

FATHER
12. Name George Kraus
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Schmidtlein
15. Birthplace Germany

16 (a) Informant Mrs. Amanda Kraus - wife
(b) Address 404 N. Glover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 APR 7 - 1948 (Date rec'd by registrar) Huntington Williams, M.D.

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1948, at 11:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1948 to April 4 1948, and that I last saw him alive on April 4 1948.

Immediate cause of death	Duration
Cardio-respiratory failure	15 minutes
Due to Cerebral Hemorrhage	3 days
Due to Hypertensive C-V Disease	? years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred N. Dann M. D.
Address Maryland Gen'l Hosp. Date signed 4/4/48

X

G61986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G61986
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D. 15-1
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1558 N. Fremont St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Florence Matthews

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife Basil

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years 84 Months Days If less than one day hr. min

9. Birthplace md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name John Wells

13. Birthplace md

MOTHER 14. Maiden Name \

15. Birthplace

16 (a) Informant: Rosie Briscoe

(b) Address 1558 N. Fremont

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/48

(c) Cemetery or crematory Mt Auburn

Location md

18 (a) Funeral director Geo. A. Kelson

(b) Address 1302 Pressman

19 APR 7 - 1948 (Date rec'd by Local Reg.) (b) Huntington Williams, M.D. (Signature of Local Reg.)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4 1948 at 10:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

Signature [illegible] M.D. Medical Examiner.

Date signed 4/5/48

VS 181

X

G61987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G61987

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 755 - W. Franklin St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-3

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits write RURAL and give town)

(d) Street No. 755 - W. Franklin St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carl O. Hamlet.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Nellie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1-29-1907

8. AGE: Years 40 | Months 2 | Days 8 | If less than one day hrs. min.

9. Birthplace Magnolia Pa. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Clarence Hamlet

13. Birthplace Va.

MOTHER 14. Maiden Name Susie Harby

15. Birthplace Va.

16 (a) Informant Nellie Hamlet

(b) Address 755 - W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-9-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

(d) Location A. Halstead

18 (a) Funeral director 918 Druid Hill

(b) Address Huntington Williams Ave.

19 (a) APR 7 1948 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-5- 1948 at 11 A M

21. I certify that death occurred on the date above stated that I attended deceased from 4/1 1948 to 4/5 1948 and that I last saw [illegible] alive on Apr 6 1948.

Immediate cause of death: Coronary Occlusion — Duration: 4 days

Due to: Hypertension Heart disease — Duration: Unknown

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature D. K. Coates

Address [illegible] Date signed 4-8-48

D. K. Coates X 1

VS (5)

G61988

G61988

C 96041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland 7-4

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 933 N. Wolfe St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Leslie Huff ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 4, 1947

8. AGE: Years | Months 4 | Days 2 | If less than one day: hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Sterling Huff

FATHER 13. Birthplace Md.

MOTHER 14. Maiden Name Edralayn Steel

MOTHER 15. Birthplace Balto Md.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Apr 10 48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location Balto Co. Md.

18 (a) Funeral director Wm H. Hett & Son

(b) Address 1124 N. Carlton St

19 (a) APR 7 - 1948 (Date rec'd by Registrar) (b) Registered

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-6- 1948, at 9 A.M. 35

21. I certify that death occurred on the date above stated; that I attended deceased from 4-6- 1948 to 4-6- 1948 and that I last saw him alive on 4-6- 1948.

Immediate Cause of death: Capillaria Bronchitis — Duration 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature O'Neil Lynaugh

Address Johns Hopkins Hosp. Date signed 4/6/48

VS 199

X

C61989

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

134a

Registered No. C61989

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County D. C.
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 923 New Jersey Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Thorne

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: female | 5 Color or race: Colored | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. 7-25-79

8. **AGE:** Years: 68 | Months: 5 | Days: 12 | If less than one day: hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER
12. Name Washington Johnson
13. Birthplace N. Carolina
14. Maiden Name Lucy Kearney
15. Birthplace N. Carolina

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof April 19 48 (month) (day) (year)
(c) Cemetery or crematory
Location Loudon Park Cemetery

18 (a) Funeral director McGuire & Elliott Corp.
(b) Address 1129 N. Eutaw St.

19 (a) APR 7 - 1948 (Date rec'd by registrar) (b) Burial permit issued by Baltimore, Md.

MEDICAL CERTIFICATION

20. **DATE OF DEATH** April 6 1948, at 9:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1948, to April 6 1948, and that I last saw her alive on April 6 1948.

Immediate cause of death Coronary Embolism and Heart failure — Duration Several yrs.

Due to Rt. Hydronephrosis, Renal Calculi & pyelonephritis right kidney

Due to Hypertensive Cardiovascular disease

Other Conditions Left hydronephrosis — thoracic — Terminally

(Include pregnancy within 3 months of death)

Date of operation 4-2-48

Major findings of operation: Stag Horn Calculi left & small kidney

of autopsy: None Obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at A.M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. **Signature** J. A. Hilbert Jr. M.D.
Address Johns Hopkins Hospital Date signed 4-6-48

VS 150

G61990 G 16633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

Registered No. G61990

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sidney Eubanks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 13 1944

8. AGE: Years	Months	Days	If less than one day
3	4	22	hr. min.

9. Birthplace Balt Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Reginald Eubanks
13. Birthplace Md

MOTHER 14. Maiden Name Annie Purnell
15. Birthplace Md

16 (a) Informant Reginald Eubanks
(b) Address 1719 Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location

18 (a) Funeral director Mrs Ruth A Elliott, Dft
(b) Address 1129 N Carey St

APR 7 - 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 4 . 1948, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Suffocation

Due to

Other Conditions Upper respiratory infection

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-3-48 at 12:41 P.M. 14/20
(b) Where did injury occur? 1719 Madison Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury fire in the house, 1st fl.

23. Signature Howard J. Mallis M.D. Medical Examiner

Date signed 4-5-48

G61991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

G61991 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16-7
(c) Hospital or institution: West Balto. Gen'l. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 Poplar Grove
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel H. Rose

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	216-03-7231

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Margaret L. (Higgins)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/16/02

8. AGE: Years	Months	Days	If less than one day
45	8	19	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation foreman
11. Industry or business

FATHER
12. Name Wm. Rose
13. Birthplace Va

MOTHER
14. Maiden Name Mary Worrell
15. Birthplace Va

16 (a) Informant Margaret L. Rose (wife)
(b) Address 15[illegible] Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Balto., Md.

18 (a) Funeral director Wm. D. Tepper & Son
(b) Address Balto., Md.

4-[illegible]-[illegible] (b) [illegible]
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1945, at 9.05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fatty degeneration of Ulcer

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earle M. Rogers M.D.
Medical Examiner.
Date signed 4-6-45

C61992

BALTIMORE CITY HEALTH DEPARTMENT 1948 C61992

Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Street
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7413 Harford Rd, Carney, Balt. 14. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME RAYMOND B. MEAGHER

3 (b) If veteran, name war: WW #1

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife: Mrs Emma Meagher
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr Nov. 25, 1896

8. AGE: Years	Months	Days	If less than one day: hr.	min.
51	4	11		

9. Birthplace Balto. Maryland (Town, county, and state)
10. Usual Occupation Farmer, Baltimore Hardware
11. Industry or business

FATHER
12. Name Mr Chas Meagher
13. Birthplace Maryland

MOTHER
14. Maiden Name Frances Blair
15. Birthplace Maryland

16 (a) Informant Mrs Emma Meagher
(b) Address 9413 Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/48 (month) (day) (year)
(c) Cemetery or crematory: Loraine
Location: Balto Co. Md

18 (a) Funeral director: Wm J. Pickett Sons
(b) Address: Belloy Md.

19 (a) Filed APR 7 1948 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1948, at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/3 1948 to 4/6 1948, and that I last saw him alive on 4/6 1948.

Immediate cause of death: Coronary Occlusion with myocardial infarction

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 3 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jas G. Scatty, M.D.
Address Union Memorial Hospital Signed 4/6/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G61993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G61993

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 Hampton Lane (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian T. Elliott

3 (b) If veteran, name war: No
3 (c) Social Security Account No: No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife John S. Elliott
6 (c) If alive, give age ____ years

7. Birth date of deceased mo., day, yr. May 29, 1891

8. AGE: Years	Months	Days	If less than one day: hr.	min
56	10	7		

9. Birthplace Des Moines Iowa (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Robert Turner
13. Birthplace Scotland

MOTHER
14. Maiden Name Ann Brown Lee
15. Birthplace Scotland

16 (a) Informant: Mrs. John S. Elliott
(b) Address 504 Hampton Lane

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 4/8/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto., Md.

18 (a) Funeral director: John J. Dickey & Son
(b) Address Baltimore, Md.

19 (a) [illegible] (Date received by registrar)

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1948, at 9:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1948 to April 6 1948, and that I last saw her alive on April 6 1948

Immediate cause of death: Uremia, Cardiac Decompensation
Due to: Hypertension and Cardiovascular Renal Disease
Due to: Descent

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy: C.V.A. Dr. and

Duration

PHYSICIAN
(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature W. H. Schnitzler M.D.
Address Mercy Date signed 4-6-48

661994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

661994

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 631 S. HANOVER ST
(c) Hospital or institution: 22-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 631 S. HANOVER ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN SCARDINA

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife JENNIE (NEE BROCATO)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUL 17, 1878

8. AGE: Years	Months	Days	If less than one day
69	8	17	hr. min.

9. Birthplace ITALY (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name CASPER SCARDINA
13. Birthplace ITALY

MOTHER
14. Maiden Name CONSETTA MARO
15. Birthplace ITALY

16 (a) Informant MRS JENNIE SCARDINA
(b) Address 631 S. HANOVER ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/8/48 (month) (day) (year)

(c) Cemetery or crematory HOLY REDEEMER
Location BALTO. MD.

18 (a) Funeral director WM J. TICHNER & SONS
(b) Address BALTO MD

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4 1948 at 10 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Feb. 14 1947, to Apr. 4 1948, and that I last saw h alive on 19

Immediate cause of death: Age + Exhaustion

Due to: Carcinoma of Rectum.

Due to: Diabetes Mellitus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3-15-47.

Major findings of operation: mass in rectum adherent to Bladder

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury
23. Signature Herbert C. Blake
Address Med arts Bldg Date signed 4/5/48

VS 150

C61995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C61995 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2112 Bank Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town.)
(d) Street No. 2112 Bank Street (If rural give location.)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen Szczesniak (Chesniak)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Louis Szczesniak

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1880

8. AGE: Years 68 | Months | Days | If less than one day: hr. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business: None

FATHER
12. Name: John Drazkiwicz
13. Birthplace: Poland

MOTHER
14. Maiden Name: Agnes Wodzynska
15. Birthplace: Poland

16 (a) Informant: Miss Alfreda Szczesniak
(b) Address: 2112 Bank Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-9-48 (month) (day) (year)
(c) Cemetery or crematory: Holy Rosary (Cem
Location: Baltimore County

18 (a) Funeral director: John H. Weber
(b) Address: 401 E. Chester Street

19 (a) (Date received) (b) Registrar

Registered by me April 9 1948

VS 150

MEDICAL CERTIFICATION 720

20. DATE OF DEATH April 6 1948 19 . at A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 15 Nov. 1947 to 4 Apr. 1948 and that I last saw her alive on 4 Apr. 1948.

Immediate cause of death: Cerebro-arteriosclerosis thrombosis — Duration: 20 yrs.

Due to: Arteriosclerosis

Due to: Hypertensive C-V disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Joseph Drozd M.D.
Address 2401 Eastern Ave Date signed 4/6/48

X

G61996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

(Registered No.) G61996

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 24 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. 31 Church St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Mason.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Bernard C Mason
6 (c) If alive, give age ?, years

7. Birth date of deceased (mo., day, yr.) 7-31-06

8. AGE: Years	Months	Days	If less than one day
41	8	6	hr. min.

9. Birthplace Longcoming, Maryland.
(Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name D. Edwards
13. Birthplace Bedford, Pa.

MOTHER
14. Maiden Name Sally Hulse
15. Birthplace Oil City, Pa.

16 (a) Informant Bernard C Mason
(b) Address Westminster, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10-48 (month) (day) (year)

(c) Cemetery or crematory Westminster
Location Carroll Co.

18 (a) Funeral director H. Bankard Son
(b) Address Westminster Md.

19 (a) [illegible] Washington Williams M.D. Registrar

APR 9 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-6 1948, at 10 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-13 1948 to 4-6 1948. and that I last saw h e r alive on 4-6 1948.

Immediate cause of death Cardio-respiratory failure — Duration

Due to Uremia

Due to Hydronephrosis, due to Carcinoma of Uterus & metastases

Other Conditions distending bladder
Vesico-vaginal fistula
(Include pregnancy within 3 months of death)

Date of operation 3/19/48

Major findings of operation: Carcinoma of Uterus & metastases along pelvic & aorta

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Fred Humphreys, Dr.
Address Franklin Square Hosp. Date signed 4/7/48

C61997 ✓ C61997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 658 Bradley St.

(c) Hospital or institution: 17-1

(d) Length of stay in hospital or inst. (yrs., mos., or days):

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 658 Bradley St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Susie P Richardson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louis Richardson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1901

8. AGE: Years 47 Months 1 Days 10 If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Horace Lee

13. Birthplace Calvert Co. Md.

MOTHER 14. Maiden Name Susie

15. Birthplace Calvert Co. Md

16 (a) Informant Otherine Lee

(b) Address 658 Bradley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 8, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St

APR 7 - 1948 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1948 at 9 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 3 1948 to April 4 1948 and that I last saw her alive on April 4 1948

Immediate cause of death: Lobar Pneumonia, (Bilateral)

Duration: Apparent 5 days.

Due to

Due to

Other Conditions Probable Chr. Glomerulonephritis (Include pregnancy within 3 months of death)

Unknown

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. Garland Linnell M. D.

Address 902 W. Franklin Date signed 4-7-48

VS 150

X

JL - 118598 G61998 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G61998 Registered No.

CERTIFICATE OF DEATH 107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 Hendricks Ct-22
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Steve Robert Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24 1947

8. AGE: Years	Months	Days	If less than one day
	3mos.	10	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ernest Allmend
13. Birthplace ?

MOTHER
14. Maiden Name Martha Brown
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 3 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Zion Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd) (Registrar) Huntington Williams (Registrar)

APR 1 - 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1948, at 1.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1948 to April 3 1948, and that I last saw h im alive on April 3 1948.

Immediate cause of death	Duration
Congenital Atresia Bile Ducts	3½ mos.
Due to	over
Due to	
Other Conditions Pneumonia	2 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hudson P. Griffin M. D.
Address Balt. City Hosp. Date signed

X 5 Apr 48

C61999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

C61999

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet St. 19-4
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 317 S. Vincent St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Julian Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	married

6 (b) Name of husband or wife Georgie Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1902

8. AGE: Years	Months	Days	If less than one day
45	10	13	hr. min.

9. Birthplace Wilmington, N.C. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name James Smith.
13. Birthplace Wilmington, N.C.

MOTHER
14. Maiden Name Annie Freeman
15. Birthplace N.C.

16 (a) Informant Georgie Smith.
(b) Address 317 S. Vincent St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12-1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St.

19 APR 9 - 1948 (Date rec'd by registrar) Washington [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 19 48 at 9:30 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-6-48 at 8 24 P M
(b) Where did injury occur? Sugar Refinery Pier
(c) Did injury occur at home, on farm, industrial place, in public place? Harbor While at work? yes
(d) Means of injury Fell from Pier

23. Signature [signature] M.D. Medical Examiner
Date signed 4-7-48

VS 181

662000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

662000 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 823 So. Ellwood Ave

(c) Hospital or institution: 1-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balt.

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 823 So. Ellwood Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mary F. Kratz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Married

6 (b) Name of husband or wife Fredrick O. Kratz

6 (c) If alive, give age yrs.

7. Birth date of deceased (mo., day, yr) 11-29-1881

8. AGE: Years	Months	Days	If less than one day
66 67	4	6	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name John Quinn

13. Birthplace Sweden

MOTHER

14. Maiden Name Rebecca Towson

15. Birthplace Maryland

16 (a) Informant Fredrick O. Kratz

(b) Address 823 So. Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-8-48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Old Fredrick Rd

18 (a) Funeral director John A. Moran

(b) Address 3000 E. Balt. St

19 (a) APR 7 1948 (Date received by registrar) (Countersigned) Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1948, at 1:25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1948, to April 5 1948 and that I last saw her alive on Apr. 5 1948.

Immediate cause of death Cerebral Hemorrhage — Duration 4 days

Due to Hypertensive Cardiovascular Disease — 10 yrs.

Due to — 6 yrs.

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Clarence W. LeGrow M.D.

Address 601 S. Ellwood Ave Date signed 4/6/48

93D

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

✓ G62001 Registered No.

G62001

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert.

(c) Hospital or institution: Mercy

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 6201 Fairoaks ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles D. Tudor.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	W

6 (b) Name of husband or wife Cora A.

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr July 31 - 1872

8. AGE: Years 75 | Months 8 | Days 6 | If less than one day hrs min

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Henry C. Tudor

13. Birthplace Ohio

MOTHER 14. Maiden Name ?

15. Birthplace

16 (a) Informant Daughter Mrs P. Fortman

(b) Address 6201 Fair Oaks Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-9-48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore

18 (a) Funeral Director Leonard J. Ruck

(b) Address 5305 Harford Road.

(Signature) Huntington Williams Registrar

APR 7 1948

VS 196

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6. 1948 at 11.29 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 19 48 to April 6 1948.

and that I last saw him alive on April 6 1948.

Immediate cause of death Decompensated heart failure

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

23. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature L.M. Flanagan M. D.

Address Mercy Date signed 4/5/48

L. M. Flanagan X

Physicians: please write the causes of death clearly and legibly. Exact age is especially important.

G62002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G62002 Registered No. 61

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 14-1

(c) Hospital or institution: Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2½ yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 1619 Eutaw Pl. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Gertude Seafede

3 (b) If veteran, name war

3 (c) Social Security Account No

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband Thomas Seafede

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. 3-26-81

8. AGE: Years 67 Months — Days — If less than one day Hr. Min.

9. Birthplace Frenchtown Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name George Neal

13. Birthplace Hagerstown Md.

MOTHER 14. Maiden Name Elizabeth Bowers

15. Birthplace Hagerstown Md.

16 (a) Informant Rosina Baker

(b) Address 1619 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Frederick Rd., Balto. 2nd

18 (a) Funeral director Walter Bowles Bradley

(b) Address 1922 N. North Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Nelson M.D. (Signature of registrar)

APR 7 - 1948

vs-1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-5-48 at 6.05 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 3-29-48 to 4-5-48, and that I last saw h[illegible] alive on 4-5-48

Immediate cause of death: Generalized arteriosclerosis

Due to: Diabetes mellitus — Duration: 4 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Findings of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Victor A. McKusick M.D.

Address Johns Hopkins Hosp. Date signed 4/6/48

X

G62003 ✓ G62003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2107 Belair Rd.
(c) Hospital or institution: 8-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2107 Belair Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY TERRESSA THOMAS

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 212-05-8883 A

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: James F. Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 31, 1879

8. AGE: Years 68 | Months 3 | Days 6 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Michael Dougherty
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Johanna Fagan
15. Birthplace: Va.

16 (a) Informant: Mrs. Edward J. Lynch
(b) Address: 3230 Kenyon Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer Cem.
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC
(b) Address: NORTH AVE & ~~Huntington Ave~~ MARYLAND AVE

19 (a) [redacted] (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1948 5.35A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1948 to April 6 1948 and that I last saw her alive on April 6 1948

	Duration
Immediate cause of death: Cerebral Hemmorhage	2 days
Due to: Hypertension	6 yrs
Due to: Arterio Sclerosis	10 yrs
Other Conditions: Nephritis	3 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Walter A Anderson
Address: 3001 Shannon Drive Date signed 4/6/48 M. D.

83a

G62004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178a

Erwin G62004
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 3-01 Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 355 Mason Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nannie L. Erwin
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1877

8. AGE: Years 70 | Months 10 | Days 24 | If less than one day: hr. min.

9. Birthplace Old Fort, N. Car. (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business Own home

FATHER
12. Name Gregson Vandergriff
13. Birthplace N. Car.

MOTHER
14. Maiden Name Caroline Morgan
15. Birthplace N. Car.

16 (a) Informant Mrs Edna Rankin
(b) Address 355 Mason Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 8, 1948
(c) Cemetery or crematory Cool Springs
Location Forest City, N. Car.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

APR 9 1948 Huntington Williams Mgr
(Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1948 at 6 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
Probably
IMMEDIATE CAUSE OF DEATH asphyxiation
Due to Illuminating gas
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐, contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-6-48 at about 4:00 3/1 P M.
(b) Where did injury occur? 355 Mason Court
(c) Did injury occur in home, on farm, industrial place, in public place? home (Specify)
(d) Means of injury Coal gas from kitchen stove

23. Signature Earl Rogers M.D. Medical Examiner.
Date signed 4-7-48

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G62005

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

97

G62005
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2009 W. Pratt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 W. Pratt St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ephraim Walker Moore

3 (b) If veteran, name war: None
3 (c) Social Security Account No: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Florence S. Moore
6 (c) If alive, give age ____ years

7. Birth date of deceased mo., day, yr: Aug 3, 1857

8. AGE: Years	Months	Days	If less than one day
88	8	3	hr. ____ min. ____

9. Birthplace: Spotswood, New Jersey (Town, county, and state)
10. Usual Occupation: Jeweler
11. Industry or business: Self

FATHER
12. Name: Thomas Moore
13. Birthplace: New Jersey

MOTHER
14. Maiden Name: Unknown
15. Birthplace: New Jersey

16 (a) Informant: Florence S. Moore
(b) Address: 2009 W Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4-9-48 (Month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Baltimore, Md

18 (a) Funeral director: Geo. C. Schmidt
(b) Address: 210 Hathaway Ave Huntingtown Williamsport, Md

APR 7 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1948 at 5:30 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 2/1 1948 to 4/6 1948 and that I last saw alive on 4/6 1948.

Immediate cause of death: Arteriosclerotic peripheral vascular disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M. D.

Address 2330 Wilkens Date signed 4/14/48

ar X

662006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

662006 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ..... If not in hospital or institution, give residence
(c) Hospital or institution: Md. Gen'l. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 509 N. Howard St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Harry B. Davis (Alias Geo. C. Mills)

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No. 578-16-1233

4. Sex: M

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 6-21-1894

8. AGE: Years 53 | Months 9 | Days 4 | If less than one day: hr. ..... min. .....

9. Birthplace Charlotte, N.C. (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER
12. Name Geo. Columbus Mills
13. Birthplace N.C.

MOTHER
14. Maiden Name Catherine R. Trantham
15. Birthplace N.C.

16 (a) Informant Mrs Coralie Prince
(b) Address 124 "M" St. N.W. Washington D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/48 (month) (day) (year)
(c) Cemetery or crematory Arlington, Va.
Location Arlington, Va.

18 (a) Funeral director W. W. Chambers & Co.
(b) Address 1300 Chapley St. N.W. D.C.

19 (a) ..... (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25th 48, at 12:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fractured skull Intracranial Hemorrhage

Due to .....

Other Conditions Syphilitic aortitis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following
(a) Date of injury March 24/48 at ..... M.
(b) Where did injury occur? Howard St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Street While at work? No
(d) Means of injury Assault

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 3/25/48

VS 181

X

G62007 Brandon X ✓ G62007

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
832a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County
(c) City or town Chicago (If outside city or town limits, write RURAL and give town)
(d) Street No. 313 E 53rd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis Brandon
3 (b) If veteran, name war
3 (c) Social Security Account No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. July 12, 1921

8. AGE: Years	Months	Days (If less than one day)	
26	8	6	0 hr 24 min

9. Birthplace Holly, Mississippi (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Louis J Burden
13. Birthplace

MOTHER
14. Maiden Name Lodie Cross
15. Birthplace Florida

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/48 (month) (day) (year)
(c) Cemetery or crematory
Location Chicago, Illinois

18 (a) Funeral director Charlie R. Lee
(b) Address 802 Madison Ave.

19 (a) Date received APR 7 1948 (b) Registrar Huntington, Williams, M.D. Registrar

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1948, at 10:45 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 4/5/48 19 to 4/5/48 19, and that I last saw him alive on 4/5/48 19.

Immediate cause of death: Respiratory failure — Duration
Due to: Sub-Arachnoid Hem.
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 4/7/48

X

G62008

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 131a

G62008
Registered No.

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore yrs. mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Del (b) County
(c) City or town Seaford (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche Wheatley
3 (b) If veteran, name war 3 (c) Social Security Account No

4 Sex female 5 Color or race White 6 (a) Single, married, widowed, or divorced
6 (b) Name of husband or wife Charles 6 (c) If alive, give age 59 years
7. Birth date of deceased, mo., day, yr. 1-8-01
8. AGE: Years 47 Months Days If less than one day hr. min
9. Birthplace Del (Town, county, and state)
10. Usual Occupation housewife
11 Industry or business

MOTHER | FATHER
12. Name Luther Cutler
13 Birthplace Del
14 Maiden Name Amanda Allen
15. Birthplace Del

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/14/48 (month) (day) (year)
(c) Cemetery or crematory Odd Fellows Cem
Location Seaford Del
18 (a) Funeral director M. H. Watson
(b) Address Seaford Del
19 (a) (Date rec'd by Registrar) (Signature of Registrar)

APR 7 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1948, at 12 M
21. I certify that death occurred on the date above stated, that I attended deceased from 3/24 1948, to 4/7 1948, and that I last saw h er alive on 4/7 1948

	Duration
Immediate cause of death Thrombosis, right middle cerebral artery	2 weeks
Due to Hypertension	2 years
Due to	
Other Conditions chronic nephritis	2 years

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation:
of autopsy: Encephalomalacia, right temporal lobe

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work) (Specify type of place)
(e) Means of injury

23. Signature Robert E. Green, M.D.
Address Johns Hopkins Hosp. Date signed April 7 1948

83C

AB-89900 G62003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51 B

G62009 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3yrs

(e) Length of stay in Baltimore (yrs., mos., or days) 41yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 819 W. Fayette St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Manoma Dixon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of husband or wife Kate Dixon dec'd

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Dec. 4 1865

8. AGE: Years	Months	Days	If less than one day hr.	min
82	4			

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Thomas Dixon-(D

13. Birthplace Md.

MOTHER 14. Maiden Name Elvira Geigas-D

15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal)

(b) Date thereof 4-9-48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Prospect

Location Mt. Airy. Frederick Co. Md.

18 (a) Funeral director E. M. Waltz

(b) Address Winfield, Md

19 APR 7 - 1948 (Date rec'd by registrar) Huntingtown Williams, Md Registrar

VS 193

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1948, at 5.30PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-21- 1947 to 4-6 1948, and that I last saw h im alive on 4-6 1948.

Immediate cause of death Bronchopneumonia

Due to

Due to

Other Conditions Carcinoma of Prostate, Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Done

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature R. T. Bunford M. D.

Address Balt. City Hosp Date signed 4-7-48

107

G62010 BAKER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

Registered No. G62010

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution: University Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County Baltimore

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 3408 Clifton & K. Terrace (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Evelyn Baker

3 (b) If veteran, name war .....

3 (c) Social Security Account No .....

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Clarence Baker

6 (c) If alive, give age 24 years

7. Birth date of deceased: mo., day, yr. Dec 6 1924

8. AGE: Years 23 | Months 4 | Days - | If less than one day: hr. ... min. ...

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Housework

11. Industry or business: at Home

FATHER

12. Name: Ernest A. Bagley

13. Birthplace: Maryland

MOTHER

14. Maiden Name: Ethel Strickland

15. Birthplace: Maryland

16 (a) Informant: Clarence Baker

(b) Address: 3408 Clifton & K. Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof ... (month) (day) (year)

(c) Cemetery or crematory: Glen Haven

Location: Baltimore Co. Md.

18 (a) Funeral director: John J. Deegan Inc.

(b) Address: 115 Light St.

19 APR 8 - 1948 Huntington Williams, M.D. (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 6 1948, at 6 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/4 1948 to 4 6 1948, and that I last saw her alive on 4 6 1948.

Immediate cause of death

Due to Hemorrhage from Ruptured Ectopic Pregnancy

Due to Medically Managed Miscarriage

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury .....

23. Signature .....

Address ..... Date signed 4/7/48

VS 159

G62011

AB-118656

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 47c

G62011
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 105 S. Schroeder St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Hess

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Margaret [illegible]
6 (c) If alive, give age [illegible] years

7. Birth date of deceased mo., day, yr. March 20- 1877

8. AGE: Years	Months	Days	If less than one day
71	-	17	hr / min

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Odd

FATHER
12. Name Killian Hess
13. Birthplace Maryland

MOTHER
14. Maiden Name Jennie Kircher-D
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof [illegible] (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Aberdeen Mill Road

18 (a) Funeral director [illegible]
(b) Address [illegible]

19 APR 8 - 1948 Huntington Williams M.D.
(Date rec'd by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6- 1948, 5.35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-3- 1948, to 4-6- 1948, and that I last saw him alive on 4-6- 1948

Immediate cause of death
Massive Hemoptysis — Duration: [illegible]
Due to Probable Bronchiogenic Carcinoma, Rt. — Duration: [illegible]
Due to — Duration:
Other Conditions — Duration:
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?) (Specify)
(e) Means of injury

23. Signature William M. Straight M.D.
Address BCH
Date signed 4/7/48

VS 150

C62818 T.F. Grant T.F. 312

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

Registered C62842

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 643 N. Calhoun St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Baby Girl Moore
3 (b) If veteran, name war ..... (c) Social Security Account No. .....

4. Sex: Female | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased: mo., day, yr. 3/29/48

8. AGE: Years | Months | Days | If less than one day: hr. ..... min. 4

9. Birthplace Md (Town, county, and state)

10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name Robert Moore
13. Birthplace Ala.

MOTHER
14. Maiden Name Annie Cunningham
15. Birthplace Ala

16 (a) Informant .....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)
(c) Cemetery or crematory.....
Location .....

18 (a) Funeral director .....
(b) Address .....

19 [illegible] 8, 1948 (b) Huntington Indiana, Mo. (Signature of local registrar) Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/31 1948, at 105 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/29 1948, to 3/31 1948, and that I last saw her alive on 3/31 1948

Immediate cause of death: Prematurity — Duration: 2 days

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

.....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury .....

23. Signature Ruby Bruce
Address Johns Hopkins Hosp Date signed 6-1-48 M. D.

Hospital Disposal

G62013

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

G62013 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Emerald Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ m
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 609 W. 33rd St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME John F. Bennett
3 (b) If veteran, name war ..... (c) Social Security Account No .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Emma F. Bennett
6 (c) If alive, give age ..... years

7. Birth date of deceased mo., day, yr. Feb 6, 1873

8. AGE: Years	Months	Days	If less than one day
70	2	1	hr ..... min .....

9. Birthplace W. Va (Town, county, and state)
10. Usual Occupation Gardner, Retired
11. Industry or business

FATHER
12. Name Henry Bennett
13. Birthplace ?

MOTHER
14. Maiden Name Nancy Wiseman
15. Birthplace ?

16 (a) Informant Alice M. Haynes
(b) Address 609 W. 33rd st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 9, 1948 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Hampden

18 (a) Funeral director Craig & Renaudette
(b) Address 3615-17 Chestnut Ave.

19 (Date rec'd by Registrar) APR 8 - 1948 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1948, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1 Dec 1947, to 6 April 1948, and that I last saw him alive on 6 April 1948.

Immediate cause of death	Duration
Bronchopneumonia	2 days
Due to Generalized debility	2 months
Due to Marked hypertrophic arthritis and marked arteriosclerosis	5 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Emil A. Henning M.D.
Address 4580 Edmondson Ave Date signed 7 April 48

VS 150

G62014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

Registered No. G62014

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

LARGE IN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3404 Fairview (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME R. BEATRICE GLICIC

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife MILTON SOL

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4 2

8. AGE: Years 35 | Months | Days | If less than one day hr min.

9. Birthplace NEW YORK (Town, county, and state)

10. Usual Occupation HOUSE WORK

11. Industry or business

FATHER 12. Name BEN F KLEIN SR

FATHER 13. Birthplace RUSSIA

MOTHER 14. Maiden Name DAISY BAUM

MOTHER 15. Birthplace BALTO

16 (a) Informant HUSBAND

(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-8-48 (month) (day) (year)

(c) Cemetery or crematory HEBREW FRIENDSHIP

Location BALTO. ST

18 (a) Funeral director JACK DAVIS INC

(b) Address 2100 EUTAW PL.

19 (a) APR 8 - 1948 (Date rec'd by registrar) (b) Tuntington Williamsport MD

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/6/48 19 at 4:30 PM

21. I certify that I took charge of the remains described above, held an Inspection Autopsy | Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Strangulation

Due to

Other Conditions Mental Depression

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4/6/48 at 3:00 P.M.
(b) Where did injury occur? 3404 Fairview
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Tied Rope around neck

23. Signature John R Davis M.D.
Medical Examiner
Date signed 4/9/48

G62015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127B

Registered No. G62015

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3535 REISTERSTOWN RD
(c) Hospital or institution: JEF
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) VV YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 3535 REIST. RD (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SARAH BOSS

3 (b) If veteran, name war ✓ 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife CHARLES BOSS
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. [illegible]

8. AGE: Years	Months	Days	If less than one day: hr	min.
73				

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business

FATHER
12. Name NATHAN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name FRIEDA
15. Birthplace RUSSIA

16 (a) Informant CHARLES BOSS
b Address 3535 REIST RD.

17 a BURIAL (Burial, cremation, or removal) b Date thereof 4-8-48 (month) (day) (year)
c Cemetery or crematory ROSEDALE
Location Phil Rd.

18 (a) Funeral director Jack Lewis Inc
b Address 2100 Eutaw Pl

19 4-8-1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-7 1948, at 12:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from DEC. 1946 to APR. 7 1948, and that I last saw her alive on April 7 1948.

Immediate cause of death: CARDIAC FAILURE — Duration

Due to HEART BLOCK

Due to HYPERTENSION & ARTERIOSCLEROSIS

Other Conditions GALL BLADDER DISEASE

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Herman Seidel M.D.
Address 2404 Eutaw Pl Date signed 4/7/48

97

VS 130

G62016 Ex. Case

Released to Hosp

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. G62016

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) ..

(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:

(a) State N. Y. (b) County

(c) City or town Flushing (If outside city or town limits, write RURAL and give town)

(d) Street No. 167-10 Crocheron Ave (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Jo Ann McPhee

3 (b) If veteran, name war

3 (c) Social Security Account No

Sex Female

5 Color or race White

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age ..... years

7. Birth date of deceased mo., day, yr. 9-5-44

8 AGE: Years 3 Months 7 Days If less than one day ..... hr. ..... min.

9. Birthplace New York (Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Ralph McPhee

13. Birthplace Mass

MOTHER 14. Maiden Name Dorothy Webster

15. Birthplace N.Y.

16 (a) Informant Relative

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/8/48 (month) (day) (year)

(c) Cemetery or crematory Flushing

Location New York

18 (a) Funeral director Welch Funeral Home

(b) Address 2008 Oakdale Rd

19 (a) APR 8 - 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

vs 5 To be Approved By Dr Maldies Med-Exp

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1948, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/31 1948, to 4/7 1948, and that I last saw him alive on 4/7 1948.

Immediate cause of death Heart Failure — Duration Sudden

Due to Congenital Heart Disease — Duration 3 years

Due to .....

Other Conditions .....

(Include pregnancy within three months of death)

Date of operation 4/7/48

Major findings of operation: Pulmonic Stenosis Tetralogy of Fallot

of autopsy: Same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury .....

23. Signature James R. Cantrell, M.D.

Address The Johns Hopkins Hosp. Date signed 4/9/48

G62017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G62017

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3206 White
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3206 White Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna L. McCormick

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Christian H. McCormick
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Oct 29 1871

8. AGE: Years 76 | Months 5 | Days 1 | If less than one day hr. min

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John Barnickel
13. Birthplace Germany

MOTHER
14. Maiden Name Don't Know
15. Birthplace Germany

16 (a) Informant Christian H. McCormick
(b) Address 3206 White Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 9 7. (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Royal

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2005 Orleans St

19 (a) Apr 8 1948 (b) Filed by [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5th 1948, at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 to April 5 1948.
and that I last saw her alive on April 3 1948.

Immediate cause of death: Gastric Hemorrhage
Cause antecedent

Duration 4 hrs

Due to

Due to (b) Carcinoma of Stomach — 3 Yrs.
Other Conditions (a) Diabetes Mellitus — 3 Yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature [illegible]
Address 4331 Hayward Ave Date signed Apr 5 1948

VS 15)

11 8

G62019

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

G62019
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland N.
(b) Street address 502 HIGHLAND Ave.
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 6 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 N. HIGHLAND Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JENNIE F WILKERSON

3 (b) If veteran, name war No | 3 (c) Social Security Account No. No

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced WIDOWED

6 (b) Name of husband or wife Wm. WILKERSON
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr FEB. 19, 1870

8. AGE: Years 78 | Months 1 | Days 16 | If less than one day hr min

9. Birthplace BALTO. MD. (Town, county and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name PATRICK MORAN
13. Birthplace IRELAND

MOTHER 14. Maiden Name JENNIE L. TRACEY
15. Birthplace MD

16 (a) Informant MRS. ALBERT WARDER (DAUGHTER)
(b) Address 502 N. HIGHLAND Ave

17 (a) BURIAL (b) Date thereof 4/8/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory WESTERN
Location BALTO. MD

18 (a) Funeral director WM. V. TICKNER & SON
(b) Address BALTO. MD

19 (a) APR 8 - 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/5 1948 at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to April 5, 1948, and that I last saw her alive on April 1, 1948.

Immediate cause of death: Arteriosclerotic heart disease — Duration: 3 months
Due to Arteriosclerotic myocarditis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work)
(e) Means of injury

23. Signature M Bickerstaff M.D.
Address [illegible] Date signed 7-5-48

VS 150

G62018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G62018

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4705 Grindon Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4705 Grindon Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA A. RICKER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife George J. Ricker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12th, 1863

8. AGE: Years	Months	Days	If less than one day
85	1	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name George Oversider
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary Unknown
15. Birthplace Unknown

16 (a) Informant Mr. George J. Ricker
(b) Address 4705 Grindon Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 4/10/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Road

19 (a) APR 8 - 1948 (Date rec'd by registrar) (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7th 1948 at 11:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 2 1948 to April 7 1948 and that I last saw her alive on April 6 1948

Immediate cause of death: Sub dural Hemorrhage - Duration 3/27/48
Cardio-vascular-renal-disease
Due to — arterio-sclerosis.
arterial hypertension
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 2/2
(a) Accident, suicide, or homicide? March 27/48
(b) Date of occurrence at P. M
(c) Where did injury occur? Fell down cellar Dept. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home — While at work? Specify type of place) Janitor
(e) Means of injury

23. Signature Louis F. Krumrein M. D.
Address 222 N Kenwood Ave Date signed

Thomas J. Mullaney, M.D. April 8/48

VS 150

G62020

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92 E

Registered No. G62020

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution
(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If nursing or boarding home, give name)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME
3. (b) If veteran, name war
3. (c) Social Security Account No.

4. Sex
5. Color or race
6. Single, married, widowed, or divorced
6. (b) Name of husband or wife
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)
8. AGE: Years Months Days If less than one day, hrs. or min.
9. Birthplace (Town, County, and State)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16. (a) Informant
(b) Address

17. (a) Burial (Burial, cremation, or removal)
(b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18. (a) Funeral director
(b) Address

19. (Date rec'd by registrar) APR 8 - 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-7

21. I certify that death occurred on the date above stated, that I attended deceased from to and that I last saw h alive on

Immediate cause (a)

Due to

Due to

Other Conditions

Duration

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town, County, State)
(d) Did injury occur about home, on farm, in industrial place, in public place? While at work?
(e) Means of injury

23. Signature

Address

Date signed

VS 53

G62021

JL - 118618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G62021

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 12-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 206 E. 23rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertie Carroll

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
60 ?			hr. min.

9. Birthplace ? Baltimore
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Carroll
15. Birthplace Md

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 4-8-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E Preston St

19 (a) APR 8 - 1948 (b) Kenneth Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1948, at 11A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1948 to April 2 1948, and that I last saw h er alive on April 2 1948.

Immediate cause of death	Duration
Arteriosclerotic Gangrene of both feet	Unknown
Due to	
Due to	
Other Conditions Diabetes mellitus Malnutrition, Dehydration (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. M. Lacy, M. D.
M. D.
Address Baltimore City Hosp Date signed 4-7-48

To be approved by Medical Examiner
Dr. D. H. Kemmerer Jr., M.D.
Howard J. Malone, M.D.

VS 150

98

G62022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121R

Registered No. G62022

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard & Green Sts

(c) Hospital or institution: Univ. of Md. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1/2 d

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1510 Druid Ct. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert E. Young

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-18-3466

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Corrine

6 (c) If alive, give age years

7 Birth date of deceased (mo., day, yr.) Nov. 14, 1909

8. AGE: Years 38 Months 4 Days 20 If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10 Usual Occupation Chef Cook

11 Industry or business

FATHER

12. Name James L. Young

13 Birthplace Leary Co. Va.

MOTHER

14. Maiden Name Eliza L. Hillman

15. Birthplace Laurel, Md.

16 (a) Informant Mrs. Corrine Young

16 (b) Address 1510 Druid Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/1948 (month) (day) (year)

17 (c) Cemetery or crematory Laurel Location Baltimore, Md.

18 (a) Funeral director Mrs. Lee A. Holland

18 (b) Address 1510 Druid Hill Ave

19 APR 8 - 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/7/1948 at 3:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 4/1 1948 to 4/7 1948, and that I last saw him alive on 4/4 1948.

Immediate cause of death: Peritonitis

Due to: Uremia

Due to: Chronic Glomerular Nephritis

Other Conditions

(Include pregnancy within three months of death)

Date of operation

Major findings of operation:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)

(e) Means of injury

23. Signature

Address Date signed M D

VS 43

G62023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

Registered No. G62023

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or instn (yrs., mos., or days) 8da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write R.F.D. and give town)
(d) Street No. 301 Collins Pk. Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Neal (Meale)

3 (b) If veteran, name war: WW II

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1923

8. AGE: Years: 24 | Months: 3 | Days: 22 | If less than one day: hr. min.

9. Birthplace Turners Station, Md.
(Town, county, and state)

10. Usual Occupation: Unemployed

11. Industry or business

FATHER
12. Name: William Neal
13. Birthplace: Md.

MOTHER
14. Maiden Name: Carrie Lucy
15. Birthplace: Va.

16 (a) Informant: Carrie L. Neal
(b) Address: 140 Avon Beach Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/48

(c) Cemetery or crematory: Balto. National
Location: Baltimore, Md.

18 (a) Funeral director: Charles R. Law
(b) Address: 802 Madison Avenue

19 (a) APR 8 - 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1948, 10:50 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Stab wound of chest

Due to

Other Conditions

(Include pregnancy)

22. If an external cause was primary [✓] secondary [ ] contributing [ ] cause of death, fill in the following:
(a) Date of injury 4-7-48 at 12:30 P.M.
(b) Where did injury occur? Potters Station
(c) Did injury occur at home (or farm, street, factory, or public place)? Public Where? no
(d) Means of injury: Stab Penetrating

23. Signature: Earle Royer M.D.
Medical Examiner.
Date signed 4-7-48

VS 131

062024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1312a

062024 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1711 Eagle St

(c) Hospital or institution South Balto Gen Hosp 24

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1459 Stevenson St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Allen

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-3924

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Marie

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr) 1903

8. AGE: Years	Months	Days	If less than one day: hr.	min.
44				

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Tally man

11. Industry or business

FATHER 12. Name Joseph Allen

13. Birthplace Md.

MOTHER 14. Maiden Name Esther Phillips

15. Birthplace Md.

16 (a) Informant Mrs. Marie Allen

(b) Address 1459 Stevenson St

17 (a) Burial (b) Date thereof 4/13/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Annapolis Blvd.

18 (a) Funeral director Chas. F. Dill

(b) Address 1501 E. Fort Ave.

19 (a) APR 8 - 1948 by Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1948, at 7:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 24 1948, to April 5 1948, and that I last saw him alive on April 5 1948.

Immediate cause of death: Cardio-renal failure — Duration: 2 weeks

Due to: Hemochromatosis — Duration: 2 years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)

(e) Means of injury

23. Signature Harold Rillon M. D.

Address South Balto Gen Hosp Date signed April 5

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

662025

Registered No. G62025

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2303 Druid Hill Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2303 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Birdie V Young
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	C	married

6 (b) Name of husband or wife A Young
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 3/17/98

8. AGE: Years	Months	Days	If less than one day
50	-	19	hr. min.

9. Birthplace Baltimore City (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name William H Holland
13. Birthplace West River, Md

MOTHER
14. Maiden Name Josephine Scott
15. Birthplace Baltimore City

16 (a) Informant Josephine Murray
(b) Address 2303 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/48
(c) Cemetery or crematory Arbutus Memorial
Location Parking, Arbutus Md

18 (a) Funeral director Robert L Williams
(b) Address 1515 McElderry St

APR 8 - 1948 Huntington Williams Jr
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1948, at 4:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 1947 to April 5 1948, and that I last saw h[illegible] alive on April 5 1948.

Immediate cause of death Carcinomatosis
Due to Carcinoma of Ovary
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 1 yr.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clifford A Muncaster M. D.
Address 2009 Druid Hill Date signed 4-6-48

VS 150

G62026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G62026 Registered No. 111B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2539 W Fairmont Ave
(c) Hospital or institution: 20

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give name)
(d) Street No. 2539 W Fairmont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna ~~Christian~~ Eliz. Benner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color of race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Christian Benner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 20-1896

8. AGE: Years 52 | Months 3 | Days 5 | If less than one day hr. min

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name George Bachmann
13. Birthplace Germany

MOTHER 14. Maiden Name Catherine Riegand
15. Birthplace Germany.

16 (a) Informant Christian Benner
(b) Address 2539 W. Fairmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10-48 (month) (day) (year)

(c) Cemetery or crematory Western Cem
Location Edmondson Ave

18 (a) Funeral director John A. Miller
(b) Address 2324 Jefferson St

19 (a) Apr 8 - 1948 Huntington Indiana
(Date received by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 19 48 at 12:45 P.M.

21. I certify that I took charge of the remains described above, held an Ext & Insp thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Pulmonary Edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Kefauver M.D.
Medical Examiner
Date signed 7/7/48

VS 191

No. G62027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G62027

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 744 Hanover St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
744 (b) Street No. Hanover St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Thomas

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Widow

6 (b) Name of husband or wife Martha Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1887

8. AGE: Years	Months	Days	If less than one day
60	7		hr min

9. Birthplace Linton W.Va.
(Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER 12. Name Hutsmore
13. Birthplace

MOTHER 14. Maiden Name Mary ?
15. Birthplace Md.

16 (a) Informant Della Lutzman
(b) Address 744 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 9, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) APR 8 - 1948 (Date rec'd by registrar) (b) Huntington Hollingsworth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1948 at 12:47 M

21. I certify that death occurred on the date above stated, that I attended deceased from 3/31 1948 to 4/4 1948 and that I last saw deceased alive on 4/4 1948.

Immediate cause of death
Pneumonia Due to Fibrosis

Duration
4 days

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. A. Capers
Address 744 Hanover St Date signed 4/5/48

VS 150

F/C Coming

G62028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

Registered No. G62028

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1633 Westwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Over 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1633 Westwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Hillburne

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife Caroline Hillburn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7, 1860

8. AGE: Years	Months	Days	If less than one day
87	11	-	hr. min.

9. Birthplace Balto. Co., Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Frederick Hillburn
13. Birthplace Maryland

MOTHER
14. Maiden Name Rachel J.
15. Birthplace Maryland

16 (a) Informant Myrtle Berry
(b) Address 1633 Westwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-9-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George D. Kilson
(b) Address 1342 Pressman St

19 (a) APR 8 - 1948 (Date rec'd by registrar) (b) Evington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7, 1948. at 8:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1947. to April 7 1948. and that I last saw h alive on April 6 1948.

Immediate cause of death Chronic valvular disease of heart — Duration 54 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John E. S. Campbell M. D.

Address 639 N. Carey St Date signed 4-7-48

VS 150

X

G62029

AB-93919

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G62029

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution. Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs.

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

a State Md. b County

c City or town Baltimore (If outside city or town limits write RURAL and give town)

d Street No. 310 N. Stricker St. (If rural give location)

e) Citizen of foreign country? Yes or No)

If yes, name country

3 (a) FULL NAME Mary Steward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	?

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-?

8. AGE: Years 65? Months Days If less than one day: hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER 12. Name ?

13. Birthplace ?

MOTHER 14. Maiden Name ?

15. Birthplace ?

16 (a) Informant: Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/48 (month, day, year)

(c) Cemetery or crematory Mt Auburn

Location Md.

18 (a) Funeral director Geo. H. Nelson

(b) Address 1303 Prestman St

19 (a) APR 8 - 1948 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1948, at 6.10PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-29 1945 to 4-6 1948, and that I last saw h er alive on 4-6 1948

Immediate cause of death: Pulmonary Edema — Duration: ?

Due to: Hypertens-Arteriosclerotic Cardiovascular Disease — Duration: ?

Due to

Other Conditions: Pulmonary TBC left apex — Duration: ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following

a Accident, suicide, or homicide

b Date of occurrence at M

c Where did injury occur? (County, State)

d Did injury occur about home, on farm, or in industrial place (in public place) While at work?

e Means of injury

23. Signature Lawrence Lee Jr. M.D.

Address Baltimore City Hosp. Date signed 4-8-48

VS 1950

9 2 D

G62030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G62030 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. yrs., mos., or days 11-
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits write RURAL and give town)
(d) Street No. 1713 Bolton St (If rural give location)
(e) Citizen of foreign country? Yes or No?
If yes, name country

3. (a) FULL NAME Vivien LeVanda
(b) If veteran, name war (c) Social Security Account No.
4. Sex Female 5. Color or race White 6. (a) Single, married, widowed or divorced Married
6. (b) Name of husband or wife Joseph
(c) If alive, give age 31 years
7. Birth date of deceased (mo., day, yr.) Aug 25 1900
8. AGE: Years 47 Months 7 Days 11 If less than one day hrs. min.
9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name George Myers
13. Birthplace Penna

MOTHER 14. Maiden Name Helen Smith
15. Birthplace W. Va.

16. (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ New Cathedral
Location Balto., Md.

18. (a) Funeral director John O. Mitchell & Sons Inc.
(b) Address 1900 Eutaw Place

APR 8 - 1948 (date received by registrar) Huntington Williams, M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-6 48 at 9 20 P M
21. I certify that death occurred on the date above stated, that I attended deceased from 4-2-48 to 4-6-48, and that I last saw deceased alive on 4-6-48

Immediate cause of death Sarcoma, ? reticulum-cell type
Due to —
Due to —
Other Conditions —

Duration

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work?)
(e) Means of injury

23. Signature Lester Ward, M.D.
Address Johns Hopkins Hosp. Date signed 4-6-48

G62031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 197

G62031

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Eutaw Pl. & Brooks Lane. Esplanade Apts.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 yrs

(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Esplanade Apts. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME SIMON DALSHEIMER.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Bertha H. Dalsheimer 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1857.

8. AGE: Years	Months	Days	If less than one day: hr.	min.
90	10	4		

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Prop. Lord Balto. Press.

11. Industry or business

FATHER 12. Name David Dalsheimer,

13. Birthplace Alsace.

MOTHER 14. Maiden Name Caroline Levy,

15. Birthplace ?

16 (a) Informant Mr. Hugo Dalsheimer,

(b) Address Pk. Heights Ave. Ext. Pikesville.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4.9.48. (month) (day) (year)

(c) Cemetery or crematory Baltimore Hebrew

Location Baltimore, Md.

18 (a) Funeral director David Sonneborn & Son

(b) Address 1902 Eutaw Place.

19 (a) (b)

(Date rec'd by registrar)

MEDICAL CERTIFICATION A

20. DATE OF DEATH April 7th. 1948 at 4.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 1948. to April 7 1948. and that I last saw him alive on April 7 1948

Immediate cause of death	Duration
Senility	2 years
Due to arterio-Sclerosis, Cardiac	14 years
Due to General arterio-Sclerosis	5 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Emma B. Mayer

Address Esplanade Apts. Date signed 4/7/48

Registrar Emma E. Mayer

VS 150

G62032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 192B

Registered No. G62032

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address ~~2680 EAGLE ST~~ 501

(c) Hospital or institution: WEST BALTO. GENERAL HOSP.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 2680 EAGLE ST (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SAMUEL A. HENNAULT

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-0107

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of ~~husband or~~ wife LILLIAN A (PENSKI)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 11, 1890

8. AGE: Years	Months	Days	If less than one day
57	11	26	hr min

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business PARKER METAL CO.

FATHER 12. Name — HENNAULT

FATHER 13. Birthplace ?

MOTHER 14. Maiden Name

MOTHER 15. Birthplace

16 (a) Informant MRS SAMUEL A HENNAULT

(b) Address 2680 EAGLE ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APRIL 10 '48 (month) (day) (year)

(c) Cemetery or crematory LOUDON PARK

Location 3801 FREDERICK AVE

18 (a) Funeral director Harry N Wilhelm

(b) Address 4101 Edmondson Ave.

APR 9 - 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-7 1948 at 5 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 4-1 1948 to 4-7 1948, and that I last saw him alive on 4-7 1948.

Immediate cause of death CARDIAC FAILURE — Duration

Due to AORTIC INSUFFICIENCY

PROBABLE MITRAL STENOSIS

Due to PROBABLY RHEMATIC

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Albert Rabinstein M. D.

Address West Baltimore General Hosp. Date signed 4/7/48

G62033

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 467

Registered No. G62033

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5611 Magnolia Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1339 Herkimer St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HYRONIMUS KAHLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	widow

6 (b) Name of husband or wife late JOSEPHA DVORAK 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1875

8. AGE: Years	Months	Days	If less than one day
72	11	20	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name - Kahler
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Mrs Fred Reuter
(b) Address 5611 Magnolia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director Henry H. Wilson
(b) Address 4101 Edmondson Ave

19 (a) 4-8-1948 (b) (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1948 at 3 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3rd 1948 to April 6th 1948 and that I last saw h alive on April 3rd 1948.

Immediate cause of death

Carcinoma of Rectum — Duration: 2 years
Due to General Cerebral Metastasis — 6 months
Due to Uremia — 4 days

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A A Weinstock M. D.
Address 4603 Dk Ave Date signed 4/6/48

G62034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146

G62034

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address University Hosp

(c) Hospital or institution.

(d) Length of stay in hospital or inst. yrs., mos., or days

(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 637 W Lombard St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Mr Anthony Stankus

3 (b) If veteran, name war (c) Social Security Account No. 214-01-1829

4. Sex Male 5. Color or race W 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Barbara

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr

8. **AGE:** Years 63 Months Days If less than one day hr min

9 Birthplace Lith. (Town, county) and state

10. Usual Occupation Tailor

11 Industry or business

FATHER 12. Name Stankus

13 Birthplace Lith

MOTHER 14. Maiden Name ?

15. Birthplace Lith

16 (a) Informant BARBARA STANKUS

(b) Address 637 W. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12-48 (Month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem

Location Belair Rd

18 (a) Funeral director Joseph Lawinskas Son

(b) Address 60 E Baltimore Blvd

19 (a) [illegible] by [illegible] registrar

8-[illegible]

vs 135

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-7 1948 at 11 10 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 3-1 1948 to 4-7 1948 and that I last saw h[illegible] alive on 4-7 1948

Immediate cause of death Resp failure

Due to Ca Stomach

Due to

Other Conditions Acid gastritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City) (County) (State)

Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(d) Means of injury

23. Signature R G Kretzer, M.D.

M. D.

Address Date signed

X

DC-48-080 84
662035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157a

662035

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 DAY
(e) Length of stay in Baltimore (yrs., mos., or days) 1 DAY

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town BALTIMORE (If outside city or town limits write RURAL and give town)
(d) Street No. 311 ELM AVENUE (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME INFANT Boy SMITH

3 (b) If veteran, name war —

3 (c) Social Security Account No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8 APRIL 1948

8. AGE: Years Months Days If less than one day 0 hr 45 min

9. Birthplace BALTIMORE, MD (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name UNKNOWN
13. Birthplace —

MOTHER
14. Maiden Name AMANDA AUGUSTA SMITH
15. Birthplace BALTIMORE, MD

16 (a) Informant HOSPITAL RECORDS
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/48 (month) (day) (year)
(c) Cemetery or Crematory Sacred Heart
Location Loch Raven & Taylor Ave Roads

18 (a) Funeral Director J. J. Fahey & Sons
(b) Address 218 Light St.

APR 8 - 1948 (c) Date received by registrar Huntington Williams, MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 APRIL 1948 at 3 50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8 APRIL 1948 to 8 APRIL 1948, and that I last saw h/m alive on 8 APRIL 1948

Immediate cause of death HYDROCEPHALUS, PREMATURITY — **Duration**

Due to

Due to

Other Conditions ANKYLOSIS PRESENT ON JOINTS AND MANDIBLE
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(e) Means of injury

23. Signature Nicholas G. Patz
Address Main Maternity Date signed 8 April 48 (M.D.)

G62036 Asl-6

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 196

G62036 Registered No. 456740

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2573 W. Fayette St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Timothy F. Maguire
3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex: male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Julia M.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Jan 29th 1869
8. AGE: Years 79 Months 2 Days 9 If less than one day: hr. min.
9. Birthplace: Ireland (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business: Watchman Cork Hill Co.

FATHER
12. Name: Jeremiah Maguire
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Mary Monahan
15. Birthplace: Ireland

16 (a) Informant: Miss Catherine T. Maguire
16 (b) Address: JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/48 (month, day, year)
17 (c) Cemetery or crematory: New Cathedral Cem. Location 4300 Old Frederick Rd.
18 (a) Funeral director: John F. Cowan & Son
18 (b) Address: 901-03 W. Lollins St.
19 (a) Filed (by) (date) APR 8 1948 (Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-7-1948, at 6:00 A M
21. I certify that death occurred on the date above stated, that I attended deceased from 4-7 to 4-7 1948, and that I last saw him alive on 4-7-1948

Immediate cause of death	Duration
Hemopericardium	
Due to Rupture of the aorta	
Due to Medial Necrosis of the Aorta	
Other Conditions Rectal Polyp with hemorrhage	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Findings of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(Did injury occur about home, on farm, industrial place, in public place? While at work?) (Specify type of place)
(d) Means of injury

23. Signature: Sherman M. Millinkoff
Address: Johns Hopkins Hosp. Date signed: 4/7/48

G62037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G62037

AB-96711

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

a State Md. b County

c City or town Baltimore (If outside city or town limits, write RURAL and give town)

d Street No. 519 Rogester St. S. (If rural give location)

e Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clara Cieslewicz

3 (b) If veteran, name war

3 (c) Social Security Account No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29- 1926

8. AGE: Years 21 | Months | Days | If less than one day: hr | min

9. Birthplace Maryland (Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Steven Cieslewicz -D

13 Birthplace Md. (Baltimore)

MOTHER 14. Maiden Name Lotty Varack-or- Lottie Banach

15 Birthplace Md. (Baltimore)

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/48 (month, day, year)

(c) Cemetery or crematory St. Stanislaus

Location Mt. Carmel Road

18 (a) Funeral director M. F. Sadowski & Sons

(b) Address 1808 Eastern Avenue

19 (a) APR 8 - 1948 (Date rec'd by registrar) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6- 1948, at 7.30PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16- 1945 to 4-6- 1948, and that I last saw her alive on 4-6- 1948

Immediate cause of death

Bplt. For Advanced Pulmonary TBc

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Duration: 7 yrs.

Date of operation

Major findings of operation:

of autopsy: Not done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City, town, or county) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?

(e) Means of injury

23. Signature John Edward Morrison

Address Balto. City Hosp. Date signed 4/7/48

VS 150

G62038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓50

Registered No. G62038

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2612 Fleet St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2612 Fleet St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Jane Moersberger

3 (b) If veteran, name war —
3 (c) Social Security Account No. — — —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Wm.C.H.Moersberger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar.9,1901

8. AGE: Years	Months	Days	If less than one day
47	0	27	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name ---Hoskins
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Balto. Md.

16 (a) Informant Wm.C.H.Moersberger
(b) Address 2612 Fleet St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr.10/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto. Md.

18 (a) Funeral director 2024 Orleans St.
(b) Address Philip Sterling Sons

19 (a) APR 8 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6/48 19 . at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1947 to April 6 1948 and that I last saw h[illegible] alive on April 6 1948.

Immediate cause of death	Duration
Due to Carcinoma of Rectum	5 mo
Due to	
Other Conditions Diabetes Mellitus	2 mo.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 4-7-48 M. D.

V S 150

C62039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 192c

Registered No. C62039

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 416 N.Belnord Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 416 N.Belnord Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Rupp

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: John Rupp
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 23, 1874
8. AGE: Years 73 74 | Months 4 | Days 13 | If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name -- Herzinger
13. Birthplace Germany

MOTHER
14. Maiden Name ---
15. Birthplace Germany

16 (a) Informant Mr. John Rupp
(b) Address 416 N.Belnord Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 9/48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Mem. Park
Location Balto. Md.

18 (a) Funeral director Philip Hewig's Son
(b) Address 2024 Orleans St.

19 (a) APR 8 - 1948 (Date received by local registrar) (b) Huntington Williams M.D. (Signature of local registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6/48 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 5. 1948. to Apr 6 1948. and that I last saw h[illegible] alive on Apr. 6 1948.

Immediate cause of death — Duration

Valvular Heart disease
Due to Pneumonia
Due to
Other Conditions Gangrene Left foot due to impedus circulation
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lemuel Fraim M. D.
Address 1823 N. Broadway St. Date signed 4/7/48

G62040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G62040

1448

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Owings Mills (If outside city or town limits, write RURAL and give town)

(d) Street No. 93 Gwynn Brook Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Constantine, Leroy

3 (b) If veteran, name war No

3 (c) Social Security Account No None

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Louis L.

6 (c) If alive, give age 43 years

7. Birth date of deceased: mo., day, yr. April 15 - 1908

8. AGE: Years 39 | Months 11 | Days 22 | If less than one day: hr. min.

9. Birthplace Union Bridge, Carroll Co, Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Charles Buckingham med.

FATHER 13. Birthplace

MOTHER 14. Maiden Name Kemp

MOTHER 15. Birthplace Md

16 (a) Informant J. Leroy Constantine

16 (b) Address Gwynnbrook Ave, Owings Mills, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr-10-1948 (month) (day) (year)

17 (c) Cemetery or crematory Druid Ridge Cemetery

Location Pikesville, Md.

18 (a) Funeral director Wm Berryman & Sons

18 (b) Address Reisterstown, Md.

19 (a) APR 8 - 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-7 1948 at 1007 M

21. I certify that death occurred on the date above stated, that I attended deceased from 4-7 1948 to 4-7 1948, and that I last saw her alive on 4-7 1948

Immediate cause of death: Respiratory failure — Duration

Due to Intra cranial Hemorrhage

Due to Hypertension

Other Conditions Diabetes ?, pregnancy

(Include pregnancy within three months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (While at work) (Specify type of place)

(e) Means of injury

23. Signature A R Neuenschwander M D

Address Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically

VS (S)

83a

Dr. J. H. Haase

662041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 49a

Registered No. 662041

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2713 Christopher Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2713 Christopher Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Evelyn A. Boczucki

3 (b) If veteran, name war — 3 (c) Social Security Account No

4. Sex: female — 5. Color or race: white — 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Leon Boczucki

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr: July 14, 1908

8. AGE: Years 39 | Months 8 | Days 23 | If less than one day: hr min

9. Birthplace: Sykesville, Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER — 12. Name: William Benesme

13. Birthplace: Md.

MOTHER — 14. Maiden Name: Lillian Amos

15. Birthplace: Md.

16 (a) Informant: Mr. Leon Boczucki

(b) Address: 2713 Christopher Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-9-48 (month) (day) (year)

(c) Cemetery or crematory Location: St. Stanilaus Baltimore, Md.

18 (a) Funeral director: Leonard J. Kuck

(b) Address: 5305 Harford Road, #14

19 (a) APR 8 - 1948 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6th 1948, at 2:20 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Nov. 1947 to April 1948 and that I last saw her alive on April 6 1948

Immediate cause of death: Carcinoma of ovary with generalized metastasis — Duration:

Due to

Due to

Other Conditions: Ethanol aneastetic and aspiration (Include pregnancy within 3 months of death)

Date of operation Oct. 11th, Dec 47th

Major findings of operation: Negative

of autopsy: None

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Harry Haase M.D.

Address 1718 Madison Ave. Date signed 4/7/48 M.D.

VS 150

G62042

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G62042 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1818 Whitmore Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 1818 Whitmore Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John T. Doxzon

3 (b) If veteran, name war

3 (c) Social Security Account No

4. Sex Male 5. Color or race White 6 (a) ~~Single, married~~, widowed or ~~divorced~~ Widowed

6 (b) Name of ~~husband~~ wife Mary E. Doxzon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 13 1863

8. AGE: Years 84 Months 5 Days 24 If less than one day hr. min.

9 Birthplace Balto. Md. (Town, county and state)

10. Usual Occupation Retired Blacksmith

11. Industry or business B & O R.R.

FATHER 12. Name John T. Doxzon

13 Birthplace Balto. Md.

MOTHER 14. Maiden Name Anna (Unknown)

15. Birthplace "

16 (a) Informant Paul Doxzon

(b) Address 1818 Whitmore Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/10/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Lorraine

Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

19 APR 8 - 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1948 at 12 M

21. I certify that death occurred on the date above stated, that I attended deceased from Mar 31 1948 to Apr 7 1948, and that I last saw him alive on Apr 6 1948.

Immediate cause of death: Chr. Myocarditis

Due to:

Due to: Chr. Intestinal nephritis

Other Conditions (Include pregnancy within 3 months of death)

Duration
1945 -
1945

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Daniel Doxzon

Address 1663 W North Ave Date signed 4/7/48

VS 199

X

G62043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G62043

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 316 Dunkirk Rd. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Albert P. Jelks

3 (b) If veteran, name war —
3 (c) Social Security Account No —

4. Sex M
5. Color or race W
6 (a) ~~Single~~, married, ~~widowed or divorced~~ M.
6 (b) Name of ~~husband~~ wife Clara E. Jelks
6 (c) If alive, give age years
7. Birth date of deceased mo., day, yr 1/4/81
8. AGE: Years 67 | Months 3 | Days 3 | If less than one day hr min
9. Birthplace Balto, Md (Town, county, and state)
10. Usual Occupation Sun Paper Employee
11. Industry or business Circulation Dept.

FATHER
12. Name Cincinnatius Jelks
13. Birthplace England

MOTHER
14. Maiden Name Margretta Severe
15. Birthplace Md.

16 (a) Informant Mrs. Clara E. Jelks
(b) Address 316 Dunkirk Rd.

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 4/10/48 (month, day, year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 APR 8 - 1948 (Date received by registrar) Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1948, at 5:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1948 to April 7 1948 and that I last saw h / m alive on April 6 1948.

Immediate cause of death

Duration 5 Days

Disseminating Cancerosis of Lungs & Pleura.
Due to
Cardio Vascular disease
Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy: Diagnosing Cancerosis Dr. Ewart

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City, town, or county) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(e) Means of injury

23. Signature Norman R. Freeman Jr. M.D.
Address Union memorial Hosp. Date signed 4/9/48

VS 196

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

062043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered 062043

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3011 Guilford Avenue

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d

(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3011 Guilford Avenue (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME John William Johnson

3 (b) If veteran, name war Spanish American

3 (c) Social Security Account No 217-01-0434 A

4. Sex male

5. Color or race white

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lyda W. Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1874

8. AGE: Years 73 Months 3 Days 10 If less than one day hrs. min

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Bethlehem Steel

FATHER 12. Name John H. Johnson

13. Birthplace Maryland

MOTHER 14. Maiden Name Elisabeth Gibson

15. Birthplace Maryland

16 (a) Informant Elisabeth Whitener

(b) Address 3011 Guilford Avenue

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 4/10/48 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cemetery

Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.

(b) Address 1217 St. Paul Street

19 APR 8 - 1948 (Date rec'd by Registrar) (b) Registrar Huntington Williams

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7, 1948, at 6:05 A. M

21. I certify that death occurred on the date above stated, that I attended deceased from 2/18 1948, to 4/7 1948, and that I last saw him alive on 4/5 1948.

Immediate cause of death Arteriosclerotic heart disease — Duration 4 yrs.

Due to

Due to

Other Conditions

(Including pregnancy, if any, within three months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. Edward Leach

Address 14 E. Eager St. Date signed 4/8/48 M D

X

G62045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G62045

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Pk. Drive & 31st St.

(c) Hospital or institution: US Marine Hospital

(d) Length of stay in hospital or inst. yrs., mos., or days: 65 days

(e) Length of stay in Baltimore yrs., mos., or days: 64 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County: Baltimore

(c) City or town: Baltimore (If outside city or town limits write RURAL and give town)

(d) Street No.: 7824 Eastern Ave. (If rural give location)

(e) Citizen of foreign country? ? (Yes or No) If yes, name country

3 (a) FULL NAME: Antoni Rug Or Anthony Rog

3 (b) If veteran, name war: —

3 (c) Social Security Account No.: 213-12-6926

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Wid.

6 (b) Name of husband or wife

6 (c) If alive, give age ____ years

7. Birth date of deceased, mo., day, yr.: June 13, 1861

8. AGE: Years: 66 Months: 9 Days: 25 If less than one day: 24 hr ____ min

9. Birthplace: Poland (Town, county and state)

10. Usual Occupation: Deckhand

11. Industry or business: Seafarer

FATHER — 12. Name: Michael Rug

13. Birthplace: Poland

MOTHER — 14. Maiden Name: Elizabeth ?

15. Birthplace: Poland

16 (a) Informant: Records

(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal)

(b) Date thereof: 4-12-48 (month) (day) (year)

(c) Cemetery: ~~———~~ St. Stanislaus

Location: Baltimore, Md.

18 (a) Funeral director: George A Weber

(b) Address: 705 South Ann St

19 (a) APR 8 - 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7 19 48 at 10:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2 1948 to Apr. 7 1948, and that I last saw h im alive on Apr. 7 1948.

Immediate cause of death: Arteriosclerotic heart disease.

Chronic auricular fibrillation

~~Secon~~ Cardiac insufficiency — Duration: 10 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None done

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (While at work)

(e) Means of injury

23. Signature: John L. Wilson

John L. Wilson, Sr. Surgeon

Address: Clinical Director Date signed: 4/9/48

VS 150

X

G62046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G62046

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 10 N. Chapel St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Ross

3 (b) If veteran, name war | 3 (c) Social Security Account No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife: Louise Ross
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
40			hr. min

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Albert Ross
13. Birthplace Maryland

MOTHER
14. Maiden Name Ada Dietz
15. Birthplace Maryland

16 (a) Informant Louise Ross
(b) Address 10 N. Castle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10-1948
(c) Cemetery or crematory Mt Calvary Cem. Location Brooklyn Md

18 (a) Funeral director Elroy S. Wilson
(b) Address 1010 Bloomsbury Ave Baltimore, Md

APR 8 - 1948 (Date rec'd by Registrar) (b) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1948, at 1:25 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of Brain

Due to

Other Conditions

(Include pregnancy within three months of death)

22. If an external cause was primary ✓ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-5-48 at 1 PM
(b) Where did injury occur? 10 N. Chapel St.
(c) Did injury occur at home, on farm, under circumstances in public place? Home (While at work?) no
(d) Means of injury Gun Shot Wound

23. Signature [illegible] M.D. Medical Examiner
Date signed 4-5-48

G62047

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 57E

Registered No. G62047

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Pk. Drive & 31st St.

(c) Hospital or institution: US Marine Hospital 6 - 1

(d) Length of stay in hospital or inst. yrs., mos., or days: 6b days

(e) Length of stay in Baltimore yrs., mos., or days: life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County

(c) City or town (If outside city or town limits, write RURAL and give town): Baltimore

(d) Street No. (If rural give location): 6 N. Bond Ste

(e) Citizen of foreign country? (Yes or No): no

If yes, name country

3 (a) FULL NAME: Henry Green (also known as Wm. Boler)

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: --

4. Sex: M

5. Color or race: col

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Cannon Boler

6 (c) If alive, give age: 35 years

7. Birth date of deceased, mo., day, yr.: Aug. 18, 1907

8. AGE: Years: 40 Months: 7 Days: 28 If less than one day: hr. min.

9. Birthplace: Columbia, Miss. (Town, county and state)

10. Usual Occupation: Fireman & watertender

11. Industry or business: Seafarer

FATHER — 12. Name: John Boler

13. Birthplace: Ala.

MOTHER — 14. Maiden Name: Mary Wilson

15. Birthplace: Ala.

16 (a) Informant: Records

(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal)

(b) Date thereof: April 10-1948

(c) Cemetery or crematory: Mt Calvary Cem. Location: Brooklyn, Md.

18 (a) Funeral director: Elroy S. Wilson

(b) Address: 1000 Beautiful ave Curtis Bay Baltimore, Md.

19 (a) APR 8 - 1948 (b) Filed by (Registrar)

Registrar

VS 19

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7 19 48, at 11:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 26 19 48, to Apr. 7 19 48, and that I last saw h. alive on Apr. 7 19 48.

Immediate cause of death — Duration

Due to: Tumor of liver of undetermined type - duration unknown

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Or Title at work)

(e) Means of injury

23. Signature: Jos. H. Hart, M.D.

Address: U.S. Marine Hospital Date signed: 4/7/48

662048

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 662048

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 927 Bennett Pl (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Travers, Evelyn

3 (b) If veteran, name war
3 (c) Social Security Account No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	Col.	M.

6 (b) Name of husband or wife Authea 44
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr 1921

8. AGE: Years	Months	Days	If less than one day
27			hr min

9. Birthplace Mini Fla. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Unknown
FATHER 13. Birthplace

MOTHER 14. Maiden Name Unknown
MOTHER 15. Birthplace

16 (a) Informant Authea Travers,
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/8/48 (month) (day) (year)
(c) Cemetery or crematory Location Mem. Fla.

18 (a) Funeral director Leonard Whalen
(b) Address 6 Myrtle Ave Huntington Williams, Md

19 (a) APR 8 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 6 1948, at 2 55 M

21. I certify that death occurred on the date above stated, that I attended deceased from 4 - 3 1948, to 4 - 6 1948, and that I last saw her alive on 4 - 6 1948

Immediate cause of death: Cardio Respiratory Failure
Due to: Purulent Meningitis Organism
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Duration
5 days

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury

23. Signature L. Lapinson M.D.
Address Municipal Hosp Date signed 4 - 6 1948

VS 150

G62049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G62049

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5131 Wetheredsville Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5131 Wetheredsville Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth W. Gary

3 (b) If veteran, name war ---

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband ~~or wife~~ Everett E. Gary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1867

8. AGE: Years	Months	Days	If less than one day
81	1	15	hr. min.

9. Birthplace Baltimore Co., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William H. Ware
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah E. Lilley
15. Birthplace Md.

16 (a) Informant Mr. Everett E. Gary
(b) Address 5131 Wetheredsville Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10-48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director J. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) APR 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

6.00

20. DATE OF DEATH April 7, 19[illegible] at A. M.

21. I certify that death occurred on the date above stated, and that I attended deceased from Apr 6 19[illegible] to [illegible] and that I last saw h[illegible] alive on Apr 7 19[illegible].

Immediate cause of death	Duration
Coronary Thrombosis	2 days
Due to Hypertension	6 hours
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. C. Smith M. D.
Address 4[illegible] Belvedere Ave. Date signed Apr 8 48

VS 150

X

G62050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

78a

G62050
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Catonsville - Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. Woodlawn Run Rd.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Leroy Brown

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 218780686

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife: Ada (nee Patterson)

6 (c) If alive, give age ..... years

7. Birth date of deceased mo., day, yr: Nov. 24, 1899

8. AGE: Years: 48 | Months: 4 | Days: 15 | If less than one day: 14 hr ..... min

9. Birthplace: Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation: Painter

11. Industry or business

FATHER
12. Name: John Brown
13. Birthplace: Balto. Co, Md

MOTHER
14. Maiden Name: Ida Wisner
15. Birthplace: Balto Co. Md

16 (a) Informant: Mrs. Leroy Brown
(b) Address: Catonsville Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 11, 1948 (month) (day) (year)
(c) Cemetery or crematory: Bloede Road
Location: Butler, Balto. Co, Md.

18 (a) Funeral director: Langdon M Broyles
(b) Address: Sparks, Md.

19 (a) [illegible] Registrar (b) Huntington [illegible] Registrar

VS 155

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1948, at 3 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 3/31 1948 to 4/8 1948 and that I last saw him alive on 4/8 1948.

Immediate cause of death: Card / Resp collapse — Duration

Due to Plumbism - chronic
Hypertension
Due to Cardiac Failure
Renal Failure

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: [illegible] Taylor

Address Redwood & Greene Date signed 4/8/48 M.D.

X

G62051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G62051 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 28-4
(b) Street address 4214 MASSACHUSETTS AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ****
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY (If outside city or town limits, write RURAL and give town)
(d) Street No. 4214 MASSACHUSETTS AVE. (If rural give location)
(e) Citizen of foreign country? NO. (Yes or No) If yes, name country

3 (a) FULL NAME FRANK M. WOOLF
3 (b) If veteran, name war
3 (c) Social Security Account No. 184-22-8115

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6 (b) Name of husband or wife SINGLE
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Aug. 23. 1879

8. AGE: Years 68 | Months 7 | Days 16 | If less than one day hr min

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Insurance Agent
11. Industry or business Home Insurance Co.

FATHER
12. Name Frank M. Woolf
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Kate Taylor
15. Birthplace Baltimore Maryland

16 (a) Informant Rev. William T. Lanzcho
(b) Address 347 Spring St. Trenton 8 N. J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 9 '48 (month) (day) (year)
(c) Cemetery or crematory LONDON PARK CEMETERY
Location BALTIMORE MARYLAND
18 (a) Funeral director F. B. IRBERT & SON
(b) Address 1300 EUTAW PLACE...17
19 (a) (Signature of Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 7th. 1948 at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to April 7, 1948. and that I last saw h[illegible] alive on 4/6 1948

Immediate cause of death Coronary Thrombosis
Due to Chronic Myocarditis
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abbie H. Crowther, M.D.
Address 4009 Frederick Ave. Date signed 4/9/48

X

G62052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 8 30

Registered No. G62052

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 26 N. Bentalou St

(c) Hospital or institution: 10-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 26 N. Bentalou (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Thelma Elizabeth Payne

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Earl Edward Payne

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) June 7, 1890

8. AGE: Years 57 Months 9 Days 1 If less than one day hr. min.

9. Birthplace Logan County, W. Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business None

FATHER 12. Name William Hayes

FATHER 13. Birthplace W. Virginia

MOTHER 14. Maiden Name Octavia Estep

MOTHER 15. Birthplace W. Virginia

16 (a) Informant Earl Edward Payne

16 (b) Address 26 N. Bentalou Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10-48 (month) (day) (year)

17 (c) Cemetery or crematory London Park

Location Baltimore, Md.

18 (a) Funeral director Long & Schaub

18 (b) Address 2101 Frederick Ave.

19 (a) APR 9 - 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8, 1948, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 1946, to April 8 1948, and that I last saw deceased alive on April 7, 1948.

Immediate cause of death: Cerebral hemorrhage — Duration: 1/2 hour

Due to High blood pressure — 2 years

Due to Arteriosclerosis, general — 2 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Gilbert E Redman M.D.

Address 2517 W. Balto St. Date signed 4/10/48

VS 150

X

G62053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G62053

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2921 Belmont Avenue

(c) Hospital or institution: 11-7

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2921 Belmont Avenue (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Thomas Edgar Howard

3. (b) If veteran, name war —

3. (c) Social Security Account No. 220-07-496

4. Sex male

5. Color or race white

6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Frances I. Howard

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1866

8. AGE: Years 81 Months 7 Days 20 If less than one day hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Shirt Designer

11. Industry or business Marboro Shirt Company

FATHER

12. Name Thomas L. Howard

13. Birthplace England

MOTHER

14. Maiden Name Margaret Roe

15. Birthplace New York

16. (a) Informant Sarah Howard

(b) Address 2921 Belmont Avenue

17. (a) removal (Burial, cremation, or removal)

(b) Date thereof 4/9/48 (month) (day) (year)

(c) Cemetery or crematory Glens Falls

Location Glen Falls, New York

18. (a) Funeral director Wm. Cook, Inc.

(b) Address 1217 St. Paul Street

19. (d) APR 9 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7, 1948, at 2 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from April 1948 to 7 April 1948, and that I last saw him alive on 4 April 48

Immediate cause of death: Gangrene of legs — Duration: 6 wks.

Due to: Arteriosclerosis, generalized — 8 yrs.

Due to:

Other Conditions

(Include pregnancy within three months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature Louis I Nice

Address 920 St Paul St. Date signed 7 Apr. '48 (M.D.)

VS 50

662054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

APR 14 1948 937

662054 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3331 Mc Elderry St

(c) Hospital or institution: 26-10

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 3331 Mc Elderry St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Frank T. Clemens

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-20-9417

4. Sex Male

5. Color or race White

6 (a) ~~Single~~, married, ~~widowed or divorced~~ Married

6 (b) Name of ~~husband or~~ wife Lilly M. Clemens

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22nd 1872

8. AGE: Years 76 Months 1 Days 16 If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Pressman

FATHER 12. Name Louis Clemens

13. Birthplace Md.

MOTHER 14. Maiden Name Margaret Rohleder

15. Birthplace Md.

16 (a) Informant Lilly Clemens

(b) Address 3331 Mc Elderry St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/12/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Meadow Ridge

Location Dorsey Md Howard Co

18 (a) Funeral director Williams Cook Inc

(b) Address 127 St. Paul St

19 (a) APR 9 - 1948 (b) Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8th 1948 at 1:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1938 to April 8 1948; and that I last saw ~~him~~ alive on April 6th 1948.

Immediate cause of death: Arteriosclerotic Heart disease — Duration: yrs.

Due to: General Arteriosclerosis — yrs.

Due to: Senility — yrs.

Other Conditions: None

(Include pregnancy within three months of death)

Date of operation: None

Major findings of operation: None

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. J. Chesnutt M.D.

Address 610 York Rd Towson Md Date signed April 9 1948

A. J. Chesnutt M.D.

VS (S)

G62055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G62055 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH: St Agnes Hospital
(a) Baltimore City, Maryland City
(b) Street address f
(c) Hospital or institution: 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2635 St. Paul St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH E. HICKOK

3 (b) If veteran, name war

3 (c) Social Security Account No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	White	Wid

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr January 25 1848

8. AGE: Years	Months	Days	If less than one day: hr	min
99				

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name C. R. Baker
13. Birthplace Virginia

MOTHER 14. Maiden Name Mary E. Linkous Hoker
15. Birthplace Virginia

16 (a) Informant Mary E. Hickok
(b) Address 2635 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/48 (month) (day) (year)
(c) Cemetery Prospect Hill
Location Towson Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) APR 8 - 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 April 1948 at 8:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2 April 1948 to 7 April 1948 and that I last saw h er alive on 7 April 1948.

Immediate cause of death	Duration
Respiratory failure	
Due to Pneumonia Lobular	
Due to Congenital Atelectasis + aspiration	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Atelectasis, Pneumonia

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James E. Hamill M.D.
Address Hagerstown Date signed 4/8/48

M D

78 190

662056

BALTIMORE CITY HEALTH DEPARTMENT

48-03244 CERTIFICATE OF DEATH 107

Registered No. 662056

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ... Preston Street
(c) Hospital or institution:

17

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. ... Preston
(If rural give location)
(e) Citizen of foreign country? No Yes or No?
If yes, name country

3 (a) FULL NAME Jacqueline Warren

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Negro	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. , -45

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Eugene Warren

13. Birthplace North Carolina

MOTHER — 14. Maiden Name Ellen Coleman

15. Birthplace South Carolina

16 (a) Informant Mrs. Ellen Warren

(b) Address ... Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (mo.) 4/9/48 (day) (yr.)

(c) Cemetery or crematory Mt Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles R. Law

(b) Address 802 Madison Ave Huntington Williams, Md

19 APR 9 - 1948 (Date Rec'd by registrar) Huntington Williams, Md Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 19 48 at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 3 19 48 to April 7 19 48 and that I last saw h alive on April 7 19 48

Immediate cause of death Embolism Pneumonia — Duration 4 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature W. H. Hall

Address 15 W. Preston St. Date signed 4/5/48

X

C62057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 19

C62057

102244

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Year
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside City or town limits, write RURAL and give town)
(d) Street No. NO Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Simmons

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ? ? ?

8. AGE: Years	Months	Days	If less than one day
48 ?			hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/12/48 (month) (day) (year)
(c) Cemetery or crematory Ridgeland S.C.
Location [redacted] 1948

18 (a) Funeral director [redacted]
(b) Address Geo. G. Kelson 1303 Preestman St.

19 [redacted] 9 - 1948 (Date rec'd by registrar) [redacted] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 31 - 1948, at 2.10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6 - 21 - 1946 to 3 - 31 - 1948 and that I last saw h im alive on 3 - 31 - 1948.

Immediate cause of death, Pulmonary Tbc.

Due to

Due to

Other Conditions, Gutteral Paralysis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

Signature William H. Kinlow Jr. M.D.
Address Balto. City Hosp. Date signed 5/6/48

VS 190

GG2058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. GG2058

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 S. Glover St.
(c) Hospital or institution: 1-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 703 S. Glover St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Antonina Przybylska

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Stanislaw

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr

8. AGE: Years	Months	Days	If less than one day
84			hr. min

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Szymanik
13. Birthplace Poland

MOTHER
14. Maiden Name Kuszek
15. Birthplace Poland

16 (a) Informant Stephen Przybylski
(b) Address 703 S. Glover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastern Ave.

19 APR 9 - 1948 (Date rec'd by registrar) (b) Huntington [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1948 at M

21. I certify that death occurred on the date above stated, that I attended deceased from March 19 48 to April 6 19 48 and that I last saw her alive on April 6 19 48

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertension

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Denis Kurzgratt

Address 2939 McElderry St Date signed 4/8/48

VS 150

662059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH. 12B

Registration No. 662059

GM. 117873

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. S-2
(c) Hospital or institution
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 215 Calvin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Luke Williams

3 (b) If veteran, name war

3 (c) Social Security Account No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years ? 55? | Months | Days | If less than 1 day: hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records Office, City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo MAR 24 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

APR 9 - 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 14 - 1948, at 5:45 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 3 - 2 - 19 to 3 - 14 - 1948, and that I last saw him alive on 3 - 14 - 19

Immediate cause of death

Meningitis Tuberculosis

Due to Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

weeks
yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Laurence Lee Jr.
Address Baltimore City Hospitals Date signed 3-25-48 M D

X

VS 150

Fasten white reports, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Court: Calvert and Mercer Streets

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered G62060

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 4-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL, and give town) Unknown
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unknown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
Full-term new-born baby			hr (?)5 min

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Unknown
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 30 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 APR 9 - 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1948, at 11:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐ suicide ☐ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Exposure (lack of care of new-born)

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following 4/1
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur in home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner
Date signed 3/16/48

VS 18t

C62061

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1178

Registered No. C62061

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ....
(c) Hospital or institution: Maryland Gen'l Hosp. 15-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 GARRISON BLVD (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Frank M. Ricketts
3 (b) If veteran, name war: No
3 (c) Social Security Account No: Yes
4. Sex: M
5. Color or race: Wh
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: DOROTHY M. RICKETTS (NEE Hollifield)
6 (c) If alive, give age: years
7. Birth date of deceased mo., day, yr.: JULY 6, 1907
8. AGE: Years: 40 | Months: 9 | Days: 2 | If less than one day: hr. min.
9. Birthplace: BALTO, MD. (Town, county, and state)
10. Usual Occupation: INSURANCE UNDERWRITER
11. Industry or business: WHITE & McCURLEY INC

FATHER
12. Name: ARMAH S. RICKETTS
13. Birthplace: MD

MOTHER
14. Maiden Name: ANNA RECKOCHEIK
15. Birthplace: MD

16 (a) Informant: MRS DOROTHY M. RICKETTS (wife)
16 (b) Address: 2109 GARRISON BLVD.
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/12/48 (month) (day) (year)
17 (c) Cemetery or crematory: NEW CATHEDRAL
Location: BALTO, MD
18 (a) Funeral director: WM J. McINERNY SONS
18 (b) Address: BALTO MD
19 APR 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 April 1948, at 12 M
21. I certify that death occurred on the date above stated, that I attended deceased from 3 Mar 1948 to 8 Apr 1948, and that I last saw h[im] alive on 8 Apr 1948.

Immediate cause of death: Gas Operation Atelectasis — Duration
Due to: Following Ob Fetal Gastrectomy
Due to:
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 6 Apr. 48
Major findings of operation: Duodenal Ulcer
of autopsy: Bilateral Atelectasis

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury
23. Signature: Frank G. Cassano M D
Address: Maryland Gen'l Hosp Date signed: 8 Apr 48

VS 150

G62062

AB-118739

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1314

Registered No. G62062

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 545 Kirby Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gertrude Luckett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ?-?-?

8. AGE: Years	Months	Days	If less than one day
59?			hr. min

9. Birthplace ? (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

MOTHER / FATHER

12. Name ?- (D

13. Birthplace ?

MOTHER

14. Maiden Name ? (D

15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Buried (b) Date thereof 4/12/48 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Baltimore

18 (a) Funeral director W. Halstead Hurd

(b) Address 1918 Eutaw Place

19 (a) (b) Huntington Williams Funeral Home

APR 9 - 1948

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7- 1948 at 5.10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-6- 1948 to 4-7 1948. and that I last saw h or alive on 4-7- 1948.

Immediate cause of death

Uremia

Due to Arteriolar Nephrosclerosis

Pulmonary edema

Due to asthenic case

Other Conditions Myocardial fibrosis

(Include pregnancy within 3 months of death)

Duration
?
?
?

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.

Address Baltimore City Hosp Date signed 4-8-48

VS 150

FG62063

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. FG62063

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3201 Bayonne Ave
(c) Hospital or institution: Edgewood Nursing Home 27-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 79 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3201 Bayone ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alma A Wirth

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John A Wirth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11th 1861

8. AGE: Years	Months	Days	If less than one day
86	8	27	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business at home

FATHER
12. Name Gottleib Kreissel
13. Birthplace Germany

MOTHER
14. Maiden Name Erdmuth Farbe
15. Birthplace Germany

16 (a) Informant Mrs Ida Weed
(b) Address Aylorville drive Berwin md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 9th (month) (day) (year)
(c) Cemetery or crematory Baltimore Gem City
Location

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2005 Orleans St

19 APR 9 - 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7th 1948, at 1 Ar. M

21. I certify that death occurred on the date above stated, that I attended deceased from June 15 1947 to April 7 1948, and that I last saw her alive on April 6 1948.

Immediate cause of death: Chronic myocarditis — Duration: 3 years
Due to
Due to
Other Conditions: Hypertension — 4 years
(Include pregnancy within 3 months of death)
Date of operation: none
Major findings of operation: no
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence no at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury none

23. Signature L. K. Crosby M.D.
Address 5106 Harford Rd Date signed 4/8/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

062064 48-07399

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 161a

Registered No. 062064

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore yrs. mos., or days

2. USUAL RESIDENCE OF DECEASED:
a. State MD b. County
c. City or town Baltimore (If outside city or town limits write (R.F.D.) and give town)
d. Street No 2705 Barclay St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Stalnaker

3 (b) If veteran, name war —
3 (c) Social Security Account No —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. 7-6-48

8. AGE: Years | Months | Days | If less than one day: 12 hr 2 min

9. Birthplace Baltimore Md (Town, county and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Carl Henry Stalnaker
13. Birthplace W Va

MOTHER
14. Maiden Name Georgia Bayless
15. Birthplace W Va

16 a. Informant Mother
b. Address 2705 Barclay St

17 a. [redacted] cremation, [redacted]
b. Date thereof 7-8-48 (month, day, year)
c. [redacted] crematory
Location Druid Memorial

18 a. Funeral director
b. Address Huntington Williams, Md

19 (a) (Date received by registrar) APR 9 - 1948 (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-7 1948, at 9:29 M

21. I certify that death occurred on the date above stated, that I attended deceased from 7-6 1948 to 7-7 1948, and that I last saw h. alive on 7-7 1948

Immediate cause of death Atelectasis — **Duration**

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
a. Accident, suicide or homicide
b. Date of occurrence at M
c. Where did injury occur? (City or town) (County) (State)
d. Did injury occur about home, on farm, industrial place, in public place? (While at work?) (Specify)
e. Means of injury

23. Signature E R Chamberlain M.D.
Address Union Memorial Hosp Date signed 4-7-48

X

G62065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

Registered No. G62065

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2058 Eastern Ave

(c) Hospital or institution: none 2-1

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2058 Eastern Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country — — — —

3 (a) FULL NAME Margaret A. Stadter

3 (b) If veteran, name war: none

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	married

6 (b) Name of husband or wife John M. Stadter

6 (c) If alive, give age ? years

7. Birth date of deceased mo., day, yr Nov. 6, 1868

8. AGE: Years	Months	Days	If less than one day: hr.	min
79	5	2		

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER

12. Name unknown

13. Birthplace

MOTHER

14. Maiden Name unknown

15. Birthplace

16 (a) Informant Mary Di Leggi

(b) Address 2232 Bank St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director Lilly & Zeiler Inc.

(b) Address 403 S. Wolfe St.

19 APR 9 - 1948 (Date rec'd by registrar) Huntington Williams, Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8, 1948 at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-25 1946 to 4-8 1948 and that I last saw h[illegible] alive on April 6 1948.

Immediate cause of death Senility

Due to Mild myocarditis (unspecified)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1 year

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature Sigmund R. Nowak

Address 408 S. Patt. Pl. Am. Date signed 4/9/48

VS 150

X

G62066 Ulsch

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G62066

PLEASE WRITE PLAINLY, WITH UNFEADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Uniuty Hospital 27-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) ?
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4024 Echodale Ave (C).
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country – – – –

3 (a) FULL NAME Conrad Ulsch

3 (b) If veteran, name war

3 (c) Social Security Account No ?

4. Sex	5. Color or race	6 (a) Single, married, (widowed) or divorced
M	W	Married

6 (b) Name of husband or wife Margaret Driebel
6 (c) If alive, give age ? years

7. Birth date of deceased mo., day, yr June 27, 1875

8. AGE: Years	Months	Days	If less than one day
72	?	?	hr min

9. Birthplace Baltimore, Maryland
(Town, county and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Ulsch
13. Birthplace ?

MOTHER
14. Maiden Name Anna Hoffman
15. Birthplace ?

16 (a) Informant Bernard J. Ulsch (son)
(b) Address 4024 Echodale Avenue (C)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Belair Road

18 (a) Funeral director Lilly & Keiler Inc.
(b) Address 103 South Wolfe Street (E).

19 (a) APR 9 - 1948 (Date rec'd by registrar) Huntington / Milnor (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-6 1948, at 6 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-1 1948, to 4-6 1948, and that I last saw him alive on 4-6 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Coronary occlusion	
Due to	
Other Conditions Complete obstruction large bowel (sigmoid) ASTHMA (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ben Bold,
Address Univ Hosp Date signed M 4-6-48 D

VS 15)

X

G62067 Plewacki ✓ G62067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1100

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Eager & Caldwell

(c) Hospital or institution: Mercy Baltimore General Hosp 4-7

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2525 Robb St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Albert Raymond Plewacki

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-4659

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Married

6 (b) Name of husband or wife Stella Plewacki

6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) Aug 10 1904

8. AGE: Years	Months	Days	If less than one day: hr.	min.
43 44	7	25		

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Chauffer

11. Industry or business

FATHER

12. Name Stanley Plewacke

13. Birthplace Germany

MOTHER

14. Maiden Name Veronica Macek

15. Birthplace Baltimore Md

16 (a) Informant Stella Plewacki

(b) Address 2525 Robb St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/48 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Dundalk Ave

18 (a) Funeral director John J Duda

(b) Address 2049 Hudson St.

19 (a) APR 9 - 1948 (Date rec'd by registrar) Huntington Williams, Md. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 April 1948 at 6 41 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 April 1948 to 7 April 1948 and that I last saw him alive on 1 April 1948

Immediate cause of death Coronary Occlusion

Due to Arteriosclerosis

Due to Empyema of lung Lung Ca

Other Conditions Amputation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible]

Address [illegible] Date signed 7 April 48 M.D.

Sen 7 L.D.

VS (50)

C62068

AB-118698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. C62068

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 764 Waesche St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernice Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Separated

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 7- 1929

8. AGE: Years	Months	Days	If less than one day
19	2	1	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name Garfield Shelton
13. Birthplace Va.

MOTHER
14. Maiden Name Emma Dotson
15. Birthplace Va.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12, 48 (month) (day) (year)

(c) Cemetery or crematory Mt. Arburn
Location Baltimore, Md.

18 (a) Funeral director Charles H. Alexander
(b) Address 1200 McCulloh St., Baltimore, Md.

19 (a) Apr 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8- 1948, at 3.45A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-5- 1948 to 4-8- 1948, and that I last saw h er alive on 4-8- 1948.

Immediate cause of death Cardiac failure — Duration

Due to Pulmonary Heart Disease — Duration 2-5 yrs

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No know

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature Wallace H Kuhns M.D.
Address Balto City Hosp Date signed 9 Apr 48

VS 150

G62069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G62069

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2532 Salem Av
(c) Hospital or institution: 13-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2532 Salem Av (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Geo. Williams

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-10-2648

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced	6 (b) Name of husband or wife	6 (c) If alive, give age
M	C	M	Jessie	years

7. Birth date of deceased (mo., day, yr.) 6/5/1895

8. AGE: Years	Months	Days	If less than one day: hr.	min.
52	10	1		

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Williams
13. Birthplace Md

MOTHER
14. Maiden Name Emily DesHields
15. Birthplace Md

16 (a) Informant Jessie Williams
(b) Address 2532 Salem Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md.

18 (a) Funeral director Hy. B. Kelly
(b) Address 1303 Pleasant St

19 (a) APR 9 - 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-6 1948 at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-10 1948 to 4/6 1948 and that I last saw him alive on 4-5 1948.

Immediate cause of death: Pulmonary Phthisis — Duration: 4

Due to — Duration: 2 m

Due to — Duration: 1

Other Conditions — Duration:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. B. Hatcher
Address 1725 Preston Date signed 4/9/48 M.D.

VS 150

X

C62070 JL - 116578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45c

Registered No. C62070

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: 18-1
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 N. Fremont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Spriggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7 Birth date of deceased mo., day, yr. March 1 ?

8. AGE: Years	Months	Days	If less than one day
72 ?	/		hr min

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Spriggs
13. Birthplace Md.

MOTHER
14. Maiden Name Nancy White
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 9, 1948 (month) (day) (year)
(c) Cemetery or crematory Laurel Cemetery
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 APR 9 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1948 at 7.40 AM PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 14 1948 to April 6 1948 and that I last saw him alive on April 6 1948

Immediate cause of death Carcinomia of floor of mouth & lip (c metastasis) Duration 3 yrs
Due to malnutrition & dehydration
Due to

Other Conditions Generalized Arteriosclerotic Cardiovascular disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature H. S. Janney
Address Baltimore City Hosp Date signed 4/7/48

VS 150

G62071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 139a

G62071 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 25-5
(b) Street address
(c) Hospital or institution Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Cypress St. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Barbara ~~Sandrowski~~ H. SZANDROWSKI
3 (b) If veteran, name war
3 (c) Social Security Account No. 217-14-2607
4. Sex female
5. Color or race white
6 (a) Single, married, widowed, or divorced married
6 (b) Name of husband ~~wife~~ Richard Sandrowski
6 (c) If alive, give age years
7. Birth date of deceased mo., day, yr. 5-1-1898
8. AGE: Years 50 Months 1 Days 7 If less than one day hr. min.
9. Birthplace Austria (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Leon Happy
13. Birthplace Europe

MOTHER
14. Maiden Name Mary Pazing
15. Birthplace Europe

16 (a) Informant Michael Sandrowski
(b) Address 1605 Cypress St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A Co.
18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave
19 (a) Date received by registrar APR 9 1948 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-8-48 at 3:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 4-7 1948 to 4-8 1948 and that I last saw him alive 4-8 1948
Immediate cause of death Cellulitis of Pelvis - abdomen.
Due to D&C. operative (3-29-48) Mayo hysterectomy + Pyelonephritis.
Other Conditions interstitial obstruction
(Include pregnancy within 3 months of death)
Date of operation 4-5-48
Major findings of operation: Pus & Gas in Pelvis, spread - Pus & cellulitis found.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Richard F. Mantus
Address Maryland General Hosp. Date signed 4-8-48 M D

G62072 PIWINSKI ✓ G62072

BALTIMORE CITY HEALTH DEPARTMENT APR 15 1948 Registered No. 473

CERTIFICATE OF DEATH

Please write plainly, with unfading ink. Every item of information should be carefully supplied. Report age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 26-7
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 925 S.
(c) City or town 295 Oldham St Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Jacob Piwinski (Also known as Jacob Pierwinski)

3 (b) If veteran, name war ?

3 (c) Social Security Account No. ?

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife none

6 (c) If alive, give age 89 years

7. Birth date of deceased mo., day, yr 7-8-(1895)

8. **AGE:** Years 53 | Months 9 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business —

FATHER
12. Name Wawzyn Piwinski
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Anthony Kantorski
(b) Address 929 S. Oldham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location O'Donnell St.

18 (a) Funeral director Lilly & Zirkin Inc.
(b) Address 103 S. Gould St.

19 (a) APR 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1948 at 3 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 4/8 1948 to 4/9 1948, and that I last saw him alive on 4/8 1948

Immediate cause of death: Cardio-respiratory failure — Duration: 1 day

Due to Carcinoma of right lung with metastasis — 9 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred N. Dann M.D.
Address Maryland Gen'l Hosp. Date signed 4/9/48

VS 159

X

G62073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G62073

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3912 Cottage Avenue

(c) Hospital or institution:

15-12

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3912 Cottage Avenue
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Matthews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife George E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1870

8. AGE: Years	Months	Days	If less than one day: hr	min
78	0	5		

9. Birthplace Martinsburg, West Virginia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Wolfe
13. Birthplace West Virginia

MOTHER
14. Maiden Name Catherine Munson
15. Birthplace West Virginia

16 (a) Informant Mrs. Mary Kirkley
(b) Address 4115 Groveland Avenue

17 (a) burial (b) Date thereof 4/10/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lorraine
Location Woodlawn, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) (Date received by registrar) APR 9 - 1948 (Signature of registrar) Huntington Williams, M.D.

VS 15c

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8, 1948 at 10:30 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 26 48 to April 8 48 and that I last saw [illegible] on April 3 48

Immediate cause of death	Duration
Acute dilatation of Heart	1 hour
Due to Coronary Sclerosis	years
Due to Diabetes	years
Other Conditions	

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which)

(e) Means of injury

23. Signature Herbert M. Foster, M.D.

Address 2722 St. Paul St. Date signed April 9, 1948

G62074

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 131a

G62074
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hosp. 16-6
(d) Length of stay in hospital or inst. (yrs. mos. days) 1
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2721 N Mosher St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Brown, Richard

3 (b) If veteran, name war

3 (c) Social Security Account No

4. Sex M | 5. Color or race Wh. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Evelyn R Brown
6 (c) If wife, give age years

7. Birth date of deceased mo., day, yr. June 12 1877

8. **AGE:** Years 70 | Months 9 | Days 26 | If less than one day hr min

9. Birthplace Ashton Howard - Md (Town, county and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Richard H Brown
13. Birthplace Md

MOTHER
14. Maiden Name Mary E Whipps
15. Birthplace Md

16 (a) Informant Mrs R H Brown
(b) Address 2721 N Mosher St Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-48 (month) (day) (year)
(c) Cemetery or crematory Lutheran Chapel
Location Clarksville Md

18 (a) Funeral director J. C. Higinbotham
(b) Address Ellicott City Md

APR 9 1948 (Date rec'd by Registrar) Huntington Williams, MD Registrar

VS (5)

MEDICAL CERTIFICATION

20. **DATE OF DEATH** April 8 1948 at 7 PM

21. I certify that death occurred on the date above stated, that I attended deceased from April 7 1948 to April 8 1948, and that I last saw him alive on April 8 1948

Immediate cause of death Acute coronary insufficiency — **Duration**

Due to Atherosclerotic heart disease & Chronic failure

Due to Generalized atherosclerosis

Other Conditions Bronchopneumonia, hypertension, nephrosclerosis (Include pregnancy within three months of death)

Date of operation

Major findings of autopsy: Same as noted

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work
(e) Means of injury

23. **Signature** Lawrence Le
Address Univ. Hosp. Date signed 4/9/48

93D

G62075

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G62075 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3506 Roland Avenue
(c) Hospital or institution: 13-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 years

2 USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3506 Roland Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Thomas Harden

3 (b) If veteran, name war: 1st World
3 (c) Social Security Account No. 232-26-4506

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Cora E. Harden
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): July 4-1891

8. AGE: Years: 56 | Months: 9 | Days: 4 | If less than one day: ____ hr. ____ min.

9. Birthplace: Berkley Co. W. Virginia (Town, county, and state)

10. Usual Occupation: Soldeper
11. Industry or business: Calvert Metal Co

FATHER
12. Name: Jack Harden
13. Birthplace: W. Virginia

MOTHER
14. Maiden Name: Priscilla Turner
15. Birthplace: W. Virginia

16 (a) Informant: Mrs. Cora E. Harden
(b) Address: 3506 Roland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: April 12-1948 (mo.)
(c) Cemetery or crematory: Norborne
Location: Martinsburg, W. Virginia

18 (a) Funeral director: Burgess Funeral Home
(b) Address: 3601 Falls Road

19 APR 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 - 8 1948, at 1:30 AM

21. I certify that I took charge of the remains described above, held an Inspection and inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary disease

Due to

Other Conditions

(Include pregnancy within three months of death)

22. If an external cause was primary ☐ or secondary (contributing) ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place?
(d) Means of injury

23. Signature: Howard C. Hudson M.D.
Medical Examiner.
Date signed 4-8-48

VS 1st

G62076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G62076 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 834 Powers Street
(c) Hospital or institution: 13-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 834 Powers Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Sherman Gilbert Fisher

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-05-9739

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sarah Ruth Fisher

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 5 1890

8. AGE: Years: 58 | Months: 2 | Days: 2 | If less than one day: hr. min

9. Birthplace Baltimore, Maryland (Town, county and state)

10. Usual Occupation Supervisor

11. Industry or business Baltimore Transit Co

FATHER
12. Name George A. Fisher
13. Birthplace Maryland

MOTHER
14. Maiden Name Rachael E. Murry
15. Birthplace Maryland

16 (a) Informant Mrs. D. Ruth Fisher
(b) Address 834 Powers Street

17 (a) Buried (Burial, cremation or removal) (b) Date thereof April 10-1948 (month) (day) (year)
(c) Cemetery or crematory Woodbridge Mem. Park
Location Howard Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) Apr 9 - 1948 (Date received by registrar) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 - 1948, at 2-10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947 to April 7 1948 and that I last saw him alive on April 7 1948

Immediate cause of death: Carcinoma of Sigmoid — Duration: 2½ yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Feb. 5, 1947

Major findings of operation: Carcinoma of Sigmoid

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work)
(e) Means of injury

23. Signature Wm. H. Grenger, M.D.
Address 1428 Kingsway Rd. Date signed 5-8-48.

VS 150

620'77

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

55E ✓ Registered No. 620'77

The information requested on this certificate is necessary for the protection of life and property. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3430 Roland Avenue
(c) Hospital or institution: 12-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3430 Roland Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Edward G. Rehmert

3 (b) If veteran, name war —
3 (c) Social Security Account No. 213-10-6410

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife Mary A. Rehmert
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Jan. 15-1877

8. AGE: Years 71 | Months 2 | Days 24 | If less than one day hr. min

9. Birthplace Baltimore, Maryland (Town, county, state)
10. Usual Occupation House Painter
11. Industry or business

FATHER
12. Name Rehmert
13. Birthplace Germany

MOTHER
14. Maiden Name Marie —
15. Birthplace Germany

16 (a) Informant Mrs. Mary A. Rehmert
(b) Address 3430 Roland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12-1948 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) APR 9 - 1948 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9- 1948, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1948 to April 9 1948 and that I last saw him alive on April 8 1948.

Immediate cause of death: Arteriosclerotic Ht Disease — Duration 8 yrs
Due to Cong. Heart Failure
Due to
Other Conditions Carcinoma of Left Parotid gland — 2 years
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(e) Means of injury

23. Signature Leonard Wallenstein
Address 848 N 36th St Date signed 4/9/48

930

G62078

JAL - 116905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G62078

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 20-8

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos.

(e) Length of stay in Baltimore (yrs., mos., or days) 23 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 104 S. Loudon Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Theresa Nagle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr May 25, 1900

8. AGE: Years	Months	Days	If less than one day
47	10	12	hr. min

9. Birthplace Mass. (Town, county, and state)

10. Usual Occupation Information Clerk

11. Industry or business Baltimore City Hospitals

FATHER

12. Name David. Nagle

13. Birthplace Ireland

MOTHER

14. Maiden Name Katherine Barrett

15. Birthplace Ireland

16 (a) Informant B. C. H. Records

b. Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) b. Date thereof 4-10-48 (month) (day) (year)

(c) Cemetery or crematory Moreland Park

Location Taylor Ave.

18 (a) Funeral director John G. Moran

b. Address 1000 E. Balt. St.

19 (a) APR 9 1948 (Date rec'd by registrar) Huntington, Indiana, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7. 1948 19 . at 3.45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 26 1948. to April 7 1948.

and that I last saw her alive on April 7 1948.

Immediate cause of death Metastatic Carcinoma

Due to Probably Bronchogenic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

Duration ?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature William M. Straight M.D.

Address BCH Date signed 4/7/48.

VS 190

G62079

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G62079

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3607 Gwynn Oak Ave.
(c) Hospital or institution: 28-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3607 Gwynn Oak Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leila Mary Harrison

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife David L. Harrison
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 2, 1867

8. AGE: Years	Months	Days	If less than one day
80	8	6	hr. min.

9. Birthplace Berkley Springs, W. Va.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Elias Rockwell
13. Birthplace West Virginia

MOTHER
14. Maiden Name Margaret Keifer
15. Birthplace United States

16 (a) Informant Mrs. Ethel E. Dowling
(b) Address 3614 Milford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10, 1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director E. Milby Lemmon
(b) Address 4510 Liberty Heights Ave.

19 (a) APR 9 - 1948 (Date rec'd by registrar) (b) Huntington Milby Lemmon (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1948, at 7.40A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1948 to April 8 1948, and that I last saw her alive on April 1 1948.

Immediate cause of death: Acute Cardiac Insufficiency — Duration: 1 hr - 24 hrs
Due to Arteriosclerosis — 10 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Grace M. Billups M. D.
Address 2224 W. North Ave. Date signed 4/9/48

VS 190

662080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 ✓

Registered No. 662080

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert Sts, 22-2

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5323 Wesley Ave. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. ~~Benjamin G. Wilkes (married)~~ Name Catherine Wilkes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Benjamin G Wilkes

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) June 16, 1890

8. AGE: Years	Months	Days	If less than one day: hr.	min.
57	9	22		

9. Birthplace Penna (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name George Kintzel (George Kintzel

13. Birthplace Pa.

MOTHER 14. Maiden Name Catherine Flexer Kate Flexer

15. Birthplace Pa

16 (a) Informant: Mr Benjamin G Wilkes

(b) Address 5323 Wesley Ave, Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Cemetery

Location Baltimore, Md.

18 (a) Funeral director E. Willis Emerson

(b) Address 4510 Liberty Heights Ave.

19 (a) APR 9 - 1948 (Date received by registrar) (b) Tuntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1948, at 11 47 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 1948 to April 8 1948, and that I last saw her alive on April 8 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension Cardiovascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?

(e) Means of injury

23. Signature John McMorgan, M.D.

Address Union Memorial Hospital Date signed 4/8/48

VS 190

8

X

G62081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓

Registered No. G62081

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Pk. Drive & 31st St.

(c) Hospital or institution: US Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) ? yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 4002 Sixth St. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME ANTONIO MANALES

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary Vallet

6 (c) If alive, give age 45 years

7. Birth date of deceased mo., day, yr [illegible]

8. AGE: Years 57 | Months 11 | Days 17 | If less than one day: hr min

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Seafarer

FATHER

12. Name Nick Manales

13. Birthplace Greece

MOTHER

14. Maiden Name Sonders Steveson

15. Birthplace Greece

16 (a) Informant Records

(b) Address US Marine Hospital

17 (a) B. (Burial, cremation, or removal) (b) Date thereof [illegible] (month) (day) (year)

(c) Cemetery or crematory London Pk.

Location 38 [illegible]

18 (a) Funeral director [illegible]

(b) Address [illegible]

19 (a) APR 9 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1948, at 1.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 5 1948 to Apr. 8 1948.

and that I last saw h im alive on Apr. 8 1948.

Immediate cause of death Arteriosclerotic cardio-vascular disease with congestive failure. — Duration 4 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature John B. Griggs M. D.

Address U.S. Marine Hospital Date signed 4-8-48

VS 150

G62082

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G62082 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Balto Gen Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 541 E. Hitting St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George H. Rebstock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: —— Edna M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16 1877

8. AGE: Years 70 | Months 9 | Days 12 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business B & O Railroad

FATHER 12. Name ? Charles Ribstock

13. Birthplace Md.

MOTHER 14. Maiden Name ? Louise A. ?

15. Birthplace Md.

16 (a) Informant Family

(b) Address Same.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 4-13-48. (month) (day) (year)

(c) Cemetery or crematory Gorsuch Home

Location Brooklyn.

18 (a) Funeral director James L. McCauley

(b) Address 130 S. Fort Ave.

19 (a) APR 9 - 1948 (Date rec'd by registrar) (b) Huntington White, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1948, at 4:15 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 5 1948 to Apr 8 1948 and that I last saw him alive on Apr 8 1948.

Immediate cause of death: Arteriosclerotic Heart Disease

Due to: Generalized arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death.)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ward Hillon M. D.

Address So. Balto Gen Hosp Date signed Apr 8

VS 150

G62083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G62083 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 21 W. Ostend St.
(c) Hospital or institution: 23-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 21 W. Ostend St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl Junius Young

3 (b) If veteran, name war: I Wald Ward
3 (c) Social Security Account No. 212-01-2726

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife: Moanni Young
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 10, 887

8. AGE: Years	Months	Days	If less than one day
60	3	29	hr. min.

9. Birthplace Kansas (Town, county, and state)
10. Usual Occupation Stock Clerk
11. Industry or business

FATHER
12. Name William Young
13. Birthplace Kansas

MOTHER
14. Maiden Name Kathy Zouck
15. Birthplace Kansas

16 (a) Informant Mrs. Moanni Young
(b) Address 21 W. Ostend St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 10 '48 (month) (day) (year)
(c) Cemetery or crematory Dallo Memorial Cemetery
Location Frederick Rd.

18 (a) Funeral director Krauss Funeral Home
(b) Address 1216 E. Charles St.

19 (a) APR 9 - 1948 (Date rec'd by Registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/F/48 19 . at 1230A M

21. I certify that death occurred on the date above (stated) that I attended deceased from 1940 19 . to 4/F/48 and that I last saw h[illegible] alive on 4/7/19 48.

Immediate cause of death	Duration
Coronary Thrombosis	30 minutes
Due to Hypertension	4 years
Due to Arteriosclerosis Auricular fibrillation	4 yrs. 2 years
Other Conditions Pernicious Anemia attended	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Isaac Miller M. D.
Address 1115 S. Charles St. Date signed

VS 150

4/9/48

G62084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G62084

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga

(c) Hospital or institution: Mercy Hospital 12-W

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days

(e) Length of stay in Baltimore (yrs., mos., or days) 5 3 yr.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Hopkins Apt. 31 E 4 St. Paul (If rural give location)

(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Fanny Gough

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Ignatius Gough (c) If alive, give age years

7. Birth date of deceased mo., day, yr. July 4, 1860

8. AGE: Years	Months	Days	If less than one day
87	9	4	hr. min.

9. Birthplace Leonardtown Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name CORNELIUS COMBS

13. Birthplace ST. MARY'S CO. MD.

MOTHER

14. Maiden Name MARY COAD

15. Birthplace ST. MARY'S CO. MD.

16 (a) Informant MRS. M. B. HOPKINS

(b) Address HOPKINS APTS. BALTO.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/10/48 (month, day, year)

(c) Cemetery or crematory ST. JOSEPH'S

Location TEXAS, MARYLAND

18 (a) Funeral director Chas. G. Evans & Son, Inc.

(b) Address 118 N. Mt. Royal Ave

19 (a) APR 9 - 1948 (Date received by registrar) Cumberland, Allegany, Md. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/8 1948, at 8:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30 1948, to 4/8 1948, and that I last saw her alive on 4/8 1948.

Immediate cause of death Cardiac failure — **Duration**

Due to Coronary occlusion

Due to Arteriosclerotic heart disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Coronary sclerosis & occlusion

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature Henry V. Chase

Address Mercy Hospital Date signed 4/8/48

VS 150

662085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Reg. No. 662085

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 Mt. Olivet Lane (south)
(c) Hospital or institution: J C-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 10 Mt. Olivet Lane (south) (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROSE TSAKALAS

3 (b) If veteran, name war: ---

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	married

6 (b) Name of husband or wife: Nick Tsakalas
6 (c) If alive, give age: 5 7 years

7. Birth date of deceased (mo., day, yr.): July 1901

8. AGE: Years	Months	Days	If less than one day: hr	min.
46	9			

9. Birthplace: Greece (Town, county, and state)
10. Usual Occupation: At home
11. Industry or business

FATHER
12. Name: Marcus Marcotis
13. Birthplace: Greece

MOTHER
14. Maiden Name: Mary Courlis
15. Birthplace: Greece

16 (a) Informant: Mr. Nick Tsakalas
(b) Address: 10 S. Mt. Olivet Lane.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory: Greek Orthodox
Location: Evangelismos

18 (a) Funeral director: Jos. L. Agnew Gun Home
(b) Address: 118 N. Mt. Street

19 (a) APR 9 - 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1948, at 8 45 A. M

21. I certify that death occurred on the date above stated, that I attended deceased from 1/10 1948 to 4/6 1948, and that I last saw her alive on 4/5 1948.

Immediate cause of death: Congestive Heart Failure
Due to Arteriosclerotic & Hypertensive Cardio-Vascular Disease

Duration: 4/5/48 — 1+ yrs.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature
Address 3629 E. Monument Date signed 4/7/48 M. D.

VS 150

G62086

JL - 117520

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 95B

Registered No. G62086

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 4-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 612 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Tracey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. May 20, 1904

8. AGE: Years	Months	Days	If less than one day: hr	min
43	10	9		

9. Birthplace N. J. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Michael Tracey
13. Birthplace Md.

MOTHER
14. Maiden Name Ann Cullen
15. Birthplace N. J.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) REMOVAL (Burial, cremation or removal) (b) Date thereof APRIL 2, 1948 (month) (day) (year)
(c) Cemetery or crematory GATES OF HEAVEN
Location EAST HANOVER, N. J.

18 (a) Funeral director WILLIAM COOK INC.
(b) Address 1217 S. PACA ST.

19 APR 9 - 1948 (Date rec'd by registrar) Constantine Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1948 at 6.15AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 16 1948 to March 29 1948, and that I last saw him alive on March 29 1948

Immediate cause of death ?

Due to Rheumatic Heart Disease ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work)
(e) Means of injury

23. Signature William M. Straight

Address 5CH Date signed 4/9/48

VS 150

062087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/61

Registered No. 062087

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2206 Lyndhurst Ave
(c) Hospital or institution
(d) Length of stay in hospital or inst yrs, mos, or days
(e) Length of stay in Baltimore yrs, mos, or days 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2206 Lyndhurst Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma M. Love

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife James B. Love
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 7 1870

8. AGE: Years 78 | Months | Days | If less than one day hr min

9. Birthplace New York (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Patrick J. McCormick
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Kerr
15. Birthplace Ireland

16 (a) Informant Madeleine Bonn
(b) Address 2206 Lynahurst Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10 1946 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John E. Moran
(b) Address 3900 Baltimore St

19 (a) Apr 9, 1946 (b) Registered by (signature) Instructor Baltimore U.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/(6) 7th 1946 at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/26 1946 to 4/6 1946 and that I last saw her alive on 4/6 1946.

Immediate cause of death	Duration
Coronary Thrombosis	1 day.
Due to	
Due to	
Other Conditions Hyp. Htn. Blood Pressure & Diabetes	4 yr.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: no

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide X
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? X (Specify type of place) While at work)
(e) Means of injury X

23. Signature A. E. Hearn
Address 7901 Fairview Date signed 4/7/46

VS 190

APR 9

9+a

62088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 62088

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: University

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County St. Mary's

(c) City or town Mechanicsville (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Frances E. Bankins

3 (b) If veteran, name war

3 (c) Social Security Account No

4. Sex: M.

5. Color or race: C.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Christie Bankins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 57 Months: Days: If less than one day: hr. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual Occupation: Housewife.

11. Industry or business

FATHER

12. Name: George Bankins

13. Birthplace: Md.

MOTHER

14. Maiden Name: Elizabeth Thomas

15. Birthplace: Md.

16 (a) Informant: Hospital Records

(b) Address: Balto. Md.

17 (a) Burial: Burial, cremation, or removal (b) Date thereof: 4-12-48 (month) (day) (year)

(c) Cemetery or crematory: St Joseph's

Location: Morganza Md

18 (a) Funeral director: W. C. Mattingly & Sons

(b) Address: Leonardtown Md.

19 (a) APR 9 1948 (Date rec'd by Local Registrar) (b) Tuntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-8-48, 19, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15-48 19 to 4-8 19 48. and that I last saw h, alive on 4-8-48 19

Immediate cause of death

(a) Coronary Failure

Due to (b) Metastatic Ca of Brain

Due to (c)

Other Conditions Exfoliative Dermatitis

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: D B Pinto Jr. M.D.

Address: University Hosp. Date signed 4-8-48

VS 153

G62089

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 77c

G62089
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 229 S. High St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 229 S. High St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Glenn Dora HOLT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years 45 | Months | Days | If less than one day: hr min

9. Birthplace Tenn (Town, county, and state)

10. Usual Occupation ?

11. Industry or business ?

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Hosp Records -
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/48
(c) Cemetery or crematory Johnson City Tenn
Location

18 (a) Funeral director Chas P Towill
(b) Address 2427 Edmondson Ave.

19 (a) (Date received) (Registrar) Huntington Williams M.D.
APR 9 - 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1948, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute alcoholism.
Acute congestive heart failure.
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (White / Negro)
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 4/6/48

X

C62090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. C62090

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Edward A Green

(c) Hospital or institution: Univ. Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Carroll

(c) City or town Westminster R F D 5

(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Scott, Eudicie

3 (b) If veteran, name war

3 (c) Social Security Account No

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr May 9 1929

8. AGE: Years 18 | Months 11 | Days - | If less than one day: hr min

9. Birthplace Lincoln Nebraska (Town, county, and state)

10. Usual Occupation Shoe factory employee

11. Industry or business Westminster

FATHER

12. Name Warren G. Scott

13. Birthplace Nebraska

MOTHER

14. Maiden Name Frances Allen

15. Birthplace Kentucky

16 (a) Informant W D Mayer

(b) Address Westminster md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 12-48 (month) (day) (year)

(c) Cemetery or crematory Bauer

Location Carroll Co

18 (a) Funeral director D Bankard. Son

(b) Address Reisterstown md.

19 APR 10 1948 (Date received by local registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-9 1948 at 10:30 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 4-8 1948 to 4-9 1948

and that I last saw her alive on 4-9 1948

Immediate cause of death Hemorrhage — Duration

Due to Separation of placenta due to attempted operation for hydatid of cleave.

Due to

Other Conditions

(Include pregnancy within three months of death)

Date of operation 4-9-48

Major findings of operation: Placenta Previa

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at AM

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Opdall Smith M.D.

Address Univ. Hosp Date signed 4-9-48

VS (B)

C62091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. C62091

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 15 E Franklin
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Nellie Powell

3 (b) If veteran, name war

3 (c) Social Security Account No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1877

8. AGE: Years	Months	Days	If less than one day hr.	min
70	11			

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Housewife

11. Business or industry Housework

FATHER
12. Name Michael Powers
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Lowry
15. Birthplace Ireland

16 (a) Informant Elizabeth Williams Friend
(b) Address 4223 Gosswood Ave

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 4/10/48 (month) (day) (year)

(c) Cemetery Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

APR 10 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1948 2:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1948 to April 8 1948.
and that I last saw her alive on April 8 1948.

Immediate cause of death: Intracranial hemorrhage

Due to Hypertensive CV disease

Due to

Other Conditions Diabetes

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature L M Brennan
Address Mercy Date signed 4/8/48.

VS 190

937

C62092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. C62092

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5045 Orville Avenue

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 5045 Orville Avenue
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine A. Johnson

3 (b) If veteran, name war: —

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: John S. Johnson

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 1, 1867

8. AGE: Years: 80 Months: 8 Days: 8 If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER

12. Name: James McKenna

13. Birthplace: Baltimore, Maryland

MOTHER

14. Maiden Name: Unknown

15. Birthplace: "

16 (a) Informant: Anna V. Peddle

(b) Address: 5045 Orville Avenue

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 4/12/48 (month) (day) (year)

(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Maryland

18 (a) Funeral director: Wm. Cook, Inc.

(b) Address: 1217 St. Paul Street

APR 10 1948 (Date rec'd by Registrar)

(b) Funeral Home Manager

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1948, at 6 A. M

21. I certify that death occurred on the date above stated, that I attended deceased from Feb. 1, 1948 to April 9, 1948, and that I last saw h alive on April 9, 1948

Immediate cause of death: Coronary Thrombosis — Duration

Due to: Arteriosclerotic Cardiovascular disease

Due to:

Other Conditions: Adenocarcinoma of Sigmoid

(Include pregnancy within 3 mos. of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature: T. A. Levering Jr. M.D.

Address 3400 Eldorado Date signed 4/9/48

VS 150

G62093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 73a

Registered No. G62093

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1430 Mt Royal Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Zilke

3 (b) If veteran, name war

3 (c) Social Security Account No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Wh	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr

8. AGE: Years	Months	Days	If less than one day: hr	min
50				

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Father-in-law
(b) Address Chicago Ill

17 (a) Funeral (burial, cremation, or removal) (b) Date thereof 4/13/48 (month) (day) (year)
(c) Cemetery or crematory Chicago Ill
Location Chicago Ill

18 (a) Funeral director Wilson & Hyde
(b) Address 1214 Druid Pl

19 APR 10 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1948 at 7:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1948 to April 9 1948 and that I last saw h im alive on April 6 1948

Immediate cause of death Anoxic crisis — Duration

Due to Persistent anoxemia

Due to Pernicious Anemia

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence Jr
Address Univ. Hosp Date signed 4/13/48

VS 150

X

G62094

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. G62094

CERTIFICATE OF DEATH 87C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 Longwood Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 Longwood Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith Bailey Coale Swope

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	married

6 (b) Name of husband or wife John L. Swope 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30 1879

8. AGE: Years	Months	Days	If less than one day
68	8	9	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wm Ellis Coale
13. Birthplace Md

MOTHER 14. Maiden Name Mary Ella Bailey
15. Birthplace Ky

16 (a) Informant John L. Swope
(b) Address 110 Longwood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 10 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address Mt Auburn & Orchard Sts

19 (a) APR 10 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1948, at 3:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1943 to Feb 8 1948 and that I last saw he alive on Feb. 7 1948

Immediate cause of death
Cardio-respiratory failure
Due to Paralysis Agitans (Parkinson's Disease)
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
10-14 d
5+ yr

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury
23. Signature Barry Tappan M. D.
Address 120 N Calvert St Date signed 4/5/48

(over)

62095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered 62095

OM 118006 1222

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1918 W. Lafayette ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Catherine Artz

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 - 8 - 1865

8. AGE: Years	Months	Days	If less than one day
83	1	-	hr. min.

9. Birthplace VA. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Jacob Huyette
13. Birthplace VA.

MOTHER
14. Maiden Name Frances B. Whiting
15. Birthplace VA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 10 1948 (month) (day) (year)
(c) Cemetery or crematory
Location Hagerstown Md.

18 (a) Funeral director Henry N. Kerkins Inc
(b) Address 20 Cutler & Orchard Sts

19 (a) APR 10 1948 (Date rec'd by registrar) (b) Huntington W. Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 8 - 1948, at 9.00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3 - 8 - 1948 to 4 - 8 - 1948, and that I last saw MPT alive on 4 - 8 - 1948.

Immediate cause of death: Bronchopneumonia. — Duration: 5 days
Due to: Generalized Arteriosclerosis
Due to:
Other Conditions: Thrombus left femoral (Include pregnancy within 3 months of death)

Date of operation 3-9-48
Major findings of operation: Gangrene 1/3 thigh
of autopsy: Bronchopneumonia

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. E. Cloe
Address 1310 Eutaw Pl. Date signed 4-7-48

VS 150

C62096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

C62096 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4620 Schenley Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4620 Schenley Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen Porter Peterson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jany 18, 1881

8. AGE: Years	Months	Days	If less than one day
67	2	20	hr. min.

9. Birthplace Boston Boston, Mass. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John W. Porter
13. Birthplace England

MOTHER 14. Maiden Name Susan L. Johnson
15. Birthplace Maine

16 (a) Informant Eunice P. Thompson
(b) Address 4620 Schenley Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 12 48 (month) (day) (year)
(c) Cemetery or crematory Greenwood Cemetery
Location Brooklyn N. Y.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 APR 10 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Address 8 Longwood Rd

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1948 at 8:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 12 1947 to Apr 8 1948 and that I last saw h alive on Apr 8 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration 1 yr.
Due to Hypertension C-V-D — 2 yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John W. Porter M.D.
Date signed Apr 8, 48

VS 150

662097

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 483

662097 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 Linden Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Linden Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Florence E. Kennard

3 (b) If veteran, name war

3 (c) Social Security Account No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. March 6, 1860

8. AGE: Years	Months	Days	If less than one day
78	1	2	hr min

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name William H. Kennard
13. Birthplace Baltimore

MOTHER
14. Maiden Name Louisa Greiner
15. Birthplace Richmond, Va.

16 (a) Informant: Harold C. Kennard
(b) Address 939 Tunner Ave., Drexel Hill, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/48 (month) (day) (year)
(c) Cemetery ~~Cemetery~~ Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director John O. Wyckoff Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) APR 10 1948 (Date rec'd by registrar) Courtesy from Williamson, Md. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1948, at 11:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1948 to 4/8 1948 and that I last saw h[illegible] alive on 4/7 1948.

Immediate cause of death	Duration
Carcinoma of the Uterus	18 Months
Due to = Abdominal Metastases	
Due to	
Other Conditions None (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Grafton Hergesheimer
Address Medical Arts Bldg. Date signed 4/9/48

VS 150

C62098

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1307

Registered No. C62098

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits write RURAL and give town)
(d) Street No 2420 E Oliver St (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Frederick P. Stein

3 (b) If veteran, name war

3 (c) Social Security Account No 212-03-7634

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Amelia

6 (c) If alive, give age 6[illegible] years

7. Birth date of deceased mo., day, yr 4-12-1884

8. AGE: Years 63 | Months 11 | Days 26 | If less than one day: hr | min

9. Birthplace Balto - Md (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER 12. Name John Stein

13. Birthplace Germany

MOTHER 14. Maiden Name Maria Sellner

15. Birthplace Germany

16 (a) Informant Wife Son

(b) Address

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 4-12-48 (month, day, year)

(c) Cemetery or crematory Loudon Park Mem.

Location Frederick Rd. - Dolfield Ave

18 (a) Funeral director [illegible]

(b) Address 2435 E. Oliver St

19 (a) APR 10 1948 (Date rec'd by registrar) (b) Remington-Williams, Md Address Mercy

VS 15)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-8 1948, at 3:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-21 1948, to 4-8 1948, and that I last saw h/ alive on 4-8 1948

Immediate cause of death: Aortic Aneurysm — Duration

Due to ASHD E

Due to Aortic Stenosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4-2-48

Major findings of operation: Explor-tomy Aortic Abdominal Aneurysm

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(e) Means of injury

23. Signature William R. Ort M.D.

Date signed 4-9-48

662099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 662099

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 E 23rd st Balto Md
(c) Hospital or institution: Beck Diagnostic Clinic
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna (b) County York County
(c) City or town Glen Rock Pa. (If outside city or town limits, write RURAL and give town)
(d) Street No. No number. Cottage Area (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Paul J. Beck

3 (b) If veteran, name war: No
3 (c) Social Security Account No. —

4. Sex: M
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Anna Catherine Hoover deceased
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 24, 1860

8. AGE: Years 88 | Months 2 mos | Days 18 days | If less than one day: — hr. — min.

9. Birthplace York County Penn (Town, county, and state)

10. Usual Occupation retired banker.

11. Industry or business

FATHER
12. Name John Frederick Beck
13. Birthplace York County Pa

MOTHER
14. Maiden Name Mathilda Fiddy?
15. Birthplace York County Pa

16 (a) Informant Brother Harvey H Beck
(b) Address 100 E. 23rd st Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 12 1948 (month) (day) (year)
(c) Cemetery or crematory Zion Lutheran
Location Glen Rock Pa.

18 (a) Funeral director H C Eagle & Son
(b) Address Glen Rock Pa. Chas H Eagle

19 (a) APR 10 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 10 1948, at 6:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1924 to Apr 10 1948
and that I last saw h[illegible] alive on Apr 10 1948

Immediate cause of death: Coronary Thrombosis — Duration: 3 hrs.
Due to: Thrombosis of Coronary Arteries
Due to: Myocardiectasis
Other Conditions: Acute abdominal Infection — 7 days
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Nathaniel M Beck M. D.
Address 100 E. 23rd st Date signed Apr 10 48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C62100

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 181

Registered No. C62100

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hospital
(c) Hospital or institution: 1514 Division St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 505 Wilson St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Pauline Priscilla Armstrong

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/9/18

8. AGE: Years	Months	Days	If less than one day
35	1	21	hr. min.

9. Birthplace Tyaskin, Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Edward Armstrong
13. Birthplace Dealin Island Md

MOTHER
14. Maiden Name Nora Evans
15. Birthplace White Heaven Md

16 (a) Informant Nora Evans
(b) Address White Heaven Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 11 1948 (month) (day) (year)
(c) Cemetery or crematory White Heaven
Location White Heaven Md

18 (a) Funeral director Joseph L. Russ
(b) Address 1216 McCulloh St

19 (a) APR 10 1948 (Date rec'd by registrar) (b) Washington Hollow Md (Signature)

VS Form

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/5 1948, at 10:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/29 1948 to 4/5 1948 and that I last saw h[illegible] alive on 4/5 1948

Immediate cause of death: Hypoproteinemia Starvation — Duration: 36 days
Due to 1st 2nd & 3rd ° Burns
Due to Ef Blaq
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: N/A
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 2/29/48 at 10:5 PM
(c) Where did injury occur? Balto. (City or town) Md (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Burn - Gasoline explosion

23. Signature D. W. Hoffler
Address Provident Hosp Date signed 4/8/48

for A. C. J. Zuhmuhl by Howard J. Maddux M. D.

Howard Not Affix

062101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. 062101

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen'l. Hosp'l
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (County) Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2589 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William M. Stoner

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-09-9283

4. Sex: M
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: William M. Stoner
6 (c) If alive, give age: 53 years
7. Birth date of deceased (mo., day, yr.): Mar. 17, 1896
8. AGE: Years: 52 | Months: | Days: 24 | If less than one day: hr. min.
9. Birthplace: Carroll Cty - Westminster
(Town, county, and state)
10. Usual Occupation: Railroad man
11. Industry or business: B. & O. R.R.

FATHER
12. Name: James M. Stoner
13. Birthplace: Md.

MOTHER
14. Maiden Name: Mary E. Roller
15. Birthplace: Md.

16 (a) Informant: John R. Byers
(b) Address: Westminster

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof APR. 12-1948
(c) Cemetery or crematory: Kriders
Location: Nr. Westminster

18 (a) Funeral director: John R. Byers
(b) Address: Westminster

19 (a) APR 10 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10 1948, at 6:25 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Cerebral edema

Due to

Other Conditions: Fatty degeneration of liver
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While (Specify)
(d) Means of injury

23. Signature: [signature] M.D.
Medical Examiner
Date signed 15 Apr 48

VS 151

52a

G62102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G62102

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1111 N. Bond St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 N. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elisha L. Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr March 4, 1895

8. AGE: Years	Months	Days	If less than one day
53	1	3	hr. min.

9. Birthplace Farmville Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Bethlehem

FATHER
12. Name Archer Jones
13. Birthplace Va

MOTHER
14. Maiden Name Emily ?
15. Birthplace Va

16 (a) Informant Elizabeth Jones
(b) Address 1111 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 11 '48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem. Location a.a. County Md.

18 (a) Funeral director Mrs. Robt. G. Elliott Dyer
(b) Address 1129 N. Carlton St.

19 (a) APR 10 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch. 18 1947 to Apl. 7 1948. and that I last saw h alive on Apl. 7 1948.

Immediate cause of death Uremia — Duration 2 Days

Due to Cerebral Apoplexy — Duration ? Yrs.

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. A. Lilly M. D.
Address 1420 E. Chase Date signed Apl 8 '48

VS 150

X

C62103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. C62103

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 810 Rutland Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d

(e) Length of stay in Baltimore (yrs., mos., or days) life -

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 810 Rutland Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Charles Raymond Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Emma

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Feb. 28, 1887

8. AGE: Years	Months	Days	If less than one day
61	1		hr. min

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Unemployed.

11. Industry or business

FATHER

12. Name Robert Anderson

13. Birthplace Md.

MOTHER

14. Maiden Name Mary Day

15. Birthplace Md.

16 (a) Informant Earl Anderson

(b) Address 810 Rutland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 9 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem. Location A. A. County Md.

18 (a) Funeral director Mrs. Robt. A. Elliott Jr.

(b) Address 1129 N. Carlins St

19 APR 10 1948 (Date rec'd by Registrar) (b) Cantington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1948 at 6 44 M

21. I certify that death occurred on the date above stated, that I attended deceased from Apr 2 1948 to Apr 7 1948 and that I last saw him alive on Apr 6 1948.

Immediate cause of death Cerebral Hemorrhage — Duration ✓ 2d

Due to Arteriosclerosis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edward Fisher M. D.

Address 22 Monument Ave Date 4/7/48

VS 150

X

G62104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G62104

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully compiled. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1717 Barnes St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hayward Coddle (Carter)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 12, 1882

8. AGE: Years	Months	Days	If less than one day: hr.	min.
65				

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Sarah ?
15. Birthplace N. C.

16 (a) Informant Minnie Patterson
(b) Address 1711 Cambridge St Phila Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 9/48 (mo.) (day)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md

18 (a) Funeral director Mrs Pott A. Elliott & Son
(b) Address 1129 N. Caroline St

19 APR 10 1948 (Date received by Registrar) (b) Lantz for Williams Mt (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1948, at 11 15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L Hoyt M.D. (Medical Examiner)
Date signed 4-7-48

VS 151

G62105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G62105

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO
(c) City or town ESSEX
(If outside city or town limits, write RURAL and give town)
(d) Street No. 48 BROENG PT. RD.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Philip E. WATTS

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 212-09-5883

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: RUTH ARMSTRONG WATTS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 11, 1902

8. AGE: Years	Months	Days	If less than one day
45	9	28	hr. min.

9. Birthplace PIKESVILLE, MD.
(Town, county, and state)

10. Usual Occupation FOREMAN

11. Industry or business AMERICAN SUGAR REFINERY CO.

FATHER
12. Name GARDNER E. WATTS
13. Birthplace PIKESVILLE MD.

MOTHER
14. Maiden Name MATTIE A. WATTS
15. Birthplace PIKESVILLE MD.

16 (a) Informant MR WM. W. ALVEY (BROTHER-IN-LAW)
(b) Address 5705 BERKLEY AVE

17 (a) BURIAL (b) Date thereof 4/12/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory DRUID RIDGE
Location PIKESVILLE MD.

18 (a) Funeral director Wm J. TICKNOR & SONS
(b) Address BALTO MD

19 (a) APR 10 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1948, at 11 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 9 1948 to Apr 9 1948 and that I last saw him alive on Apr 9 1948.

Immediate cause of death	Duration
Respiratory failure	
Due to Myocardial Infarction	1 hour
Due to Arteriosclerotic Heart Disease	5 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Fallon M. D.
Address South Balto Gen Hosp signed Apr 9

VS 150

G62106

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G62106

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3502 Clifton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4003 Garrison Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jane Schminger (Ziegler)

3 (b) If veteran, name war NO

3 (c) Social Security Account No. 056-07-2383

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife Frank -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 5, 1874

8. AGE: Years 74 | Months | Days 3 | If less than one day: hr. | min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation Retired - Sales Lady

11. Industry or business Macy's Dept Store

FATHER
12. Name Rudolph Schminger
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Wilhelmina
15. Birthplace Balto Md.

16 (a) Informant Mr. G. Price Hayden
(b) Address 2912 Guilford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/48 (month) (day) (year)
(c) Cemetery or ~~cemetery~~ Baltimore Cem
Location Balto. Md

18 (a) Funeral director Wm. J. Tietjen & Sons
(b) Address Balto, Md

19 (a) Registered by (registrar) APR 10 1948 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/8 1948, at 6 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1948 to April 8 1948, and that I last saw h[illegible] alive on April 8 1948.

Immediate cause of death
Cerebral haemorrhage
Hemiplegia
Due to Generalized arteriosclerosis
Due to Chronic hypertension
Due to

Other Conditions Arteriosclerotic type of heart disease - Cardiac hypertrophy
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration 6 weeks. Several yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature W. Michel
Address 7901 Edmondson Ave Date signed April 9 1948 M.D.

VS 150

83a

G62107

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G62107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2723 THE ALAMEDA
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9/6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2723 THE ALAMEDA (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LUCIE GERTRUDE HENDERSON

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	MARRIED

6 (b) Name of husband or wife HOWARD B. HENDERSON
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT 13 1860

8. AGE: Years	Months	Days	If less than one day
87	6	27	hr min

9. Birthplace PETERSBURG, Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business HOUSEWIFE

FATHER
12. Name JAMES W. SPAULDING
13. Birthplace Va

MOTHER
14. Maiden Name MARIETTA BROADAWAY
15. Birthplace Va

16 (a) Informant
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/12/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ GREENMOUNT
Location BALTO.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTO., MD.

19 (a) APR 10 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/9 1948, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1948 to 4/9 1948, and that I last saw her alive on 9 Apr. 1948.

Immediate cause of death [illegible]

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
A. 1 hr.
B.
C.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work?)
(e) Means of injury

23. Signature

Address Date signed M D

VS 189

X

G62108

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 469

G62108
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct. age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address APT # 243 OAKLEE VILLAGE
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. APT # 243 - OAKLEE VILLAGE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN WILLIAM VAETH

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 218-01-6689

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife LORETTA B. VAETH
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR. 6, 1891

8. AGE: Years	Months	Days	If less than one day: hr.	min.
57	0	1		

9. Birthplace BALTO. MD. (Town, county, and state)
10. Usual Occupation MUTUAL CLERK
11. Industry or business RACE TRACKS

FATHER
12. Name GEO. ADAM VAETH
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARY M. SHAFFER
15. Birthplace GERMANY

16 (a) Informant MRS. LORETTA B. VAETH (wife)
(b) Address APT 243 OAKLEE VILLAGE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/10/48 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDAL
Location BALTO. MD

18 (a) Funeral director WM. J. TICHNER & SONS
(b) Address BALTO. MD.

19 (a) APR 10 1948 (Date received by registrar) Registration No. Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH APR 7 1948, at 2 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 10 1948, to Apr 7 1948, and that I last saw h[illegible] alive on Apr 6 1948.

Immediate cause of death: Pulmonary Edema — Duration: 1 day
Due to: General Carcinomatosis
Due to: Carcinoma of Pancreas
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature James T. Fitzgerald M.D.
Address 731 Medical Arts Bldg. Date signed 4/9/48

VS 189

062109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. 062109

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet St
(c) Hospital or institution: Balto. City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Md
(If outside city limits, write RURAL after town)
(d) Street No. 153 W. Hamilton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George DIXON

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-0147

4. Sex male

5. Color or race Col-

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9-1913

8. AGE: Years 34 Months 11 Days 28 If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Holstein Mfg Co.

11. Industry or business

FATHER 12. Name William Dixon

13. Birthplace Balto.

MOTHER 14. Maiden Name Hanel Thomas

15. Birthplace Balto.

16 (a) Informant Hanel Dixon.

(b) Address 127 W Preston

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/48 (month)

(c) Cemetery or crematory Mt. Calvary Cemetery

Location Balto Md.

18 (a) Funeral director Walter B. Spriggs

(b) Address 1591 Hamburg St

19 (a) APR 10 1948 (Date received by Registrar)

(b) Huntington Williams, Md

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1948 at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 4/7/48 at 6:30 A.M. 4/1

(b) Where did injury occur? Hand - Pier 1, Light St.

(c) Did injury occur at home, on farm, industrial place, in public place? Harbor While at work? NO

(d) Means of injury Fell and dropped

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed 4/6/48

VS 151

662110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

Registered No. 662110

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1927 Brent St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leroy Supers Leroy, Chephas
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M
5. Color or race C
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr
8. AGE: Years 19 | Months | Days | If less than one day: hr | min

9. Birthplace Baltimore (town, county, and state)
10. Usual Occupation Printer
11. Industry or business

FATHER
12. Name William Chephas
13. Birthplace Dexter Md.

MOTHER
14. Maiden Name Mamie Covington
15. Birthplace Balto. Md.

16 (a) Informant Mamie Covington
(b) Address 1927 Brent St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 4 11 48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary.
Location

18 (a) Funeral director Leonard H Galen
(b) Address 6247 Myrtle ave.

19 (a) APR 10 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-7 1948 at M

21. I certify that death occurred on the date above stated, that I attended deceased from 4/7/48 to 4/7/48, and that I last saw him alive on 4/7/48.

Immediate cause of death: Pulmonary edema

Due to St. Johns

Due to Dr. Schneider's myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

of autopsy: Dr. Glenn Stephens

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Glenn Stephens M.D.
Address Univ. Hosp. Date signed 4/9/48

VS 153

C62111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. C62111

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 136 W. Lanvale St.

(c) Hospital or institution:

none

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County none

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 136 W. Lanvale St. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) **FULL NAME** Nita Pitt Daves

3 (b) If veteran, name war

3 (c) Social Security Account No

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: John C. Daves

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Nov. 11-1865

8. **AGE:** Years 82 Months 5 Days 8 If less than one day hr. min.

9. Birthplace (Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Faris C. Pitt

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant C. Gordon Pitt

(b) Address Brightside Road, Baltimore-12

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Cambridge, Mass.

18 (a) Funeral director John O. Mitchell & Sons, Inc.

(b) Address 1900 Eutaw Place

19 (a) APR 10 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. **DATE OF DEATH** April 10, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1946 to Present.

and that I last saw h alive on April 9 1948.

Immediate cause of death Cerebral hemorrhage — **Duration**

Due to Hypertension & arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (While at work) (Specify type of place)

(e) Means of injury

23. **Signature** Walter B. Bush M. D.

Address 10 E. Eager St. Date signed

VS 50

662112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 662112

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1737 N Castle
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1737 N Castle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leopold F. Mihm

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Carrie Stoecker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 17th 1874

8. AGE: Years	Months	Days	If less than one day
74	-	22	hr. min.

9. Birthplace Germany (town, county, and state)
10. Usual Occupation Cabinet Maker
11. Industry or business Retired

FATHER
12. Name Karl Mihm
13. Birthplace Germany

MOTHER
14. Maiden Name Kat. Thoms
15. Birthplace

16 (a) Informant Mrs. Carrie Mihm
(b) Address 1737 N Castle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md.

18 (a) Funeral director C. J. Tagmyer Son
(b) Address 1938 E Lafayette Ave

19 (a) APR 10 1948 (Date rec'd by registrar) (b) Lexington Mkt Baltimore Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 8th 1948 at 10:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-26-1948 to April 8 1948.
and that I last saw alive on April 8 1948

Immediate cause of death — Duration
Cerebral Hemorrhage — 2 days
Due to Arterio-Sclerosis — 6 yr
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall
Address 1631 E North Ave Date signed 4-9-1948 M.D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

63113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓170c

Registered No. 63113

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1326 Pontiac Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ellen Caves

3 (b) If veteran, name war —

3 (c) Social Security Account No. 233-34-9909

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5

8. AGE: Years	Months	Days	If less than one day: hr	min
28	4	5		

9. Birthplace W. Va.
(Town, county, and state)

10. Usual Occupation Finisher

11. Industry or business Locke Insulator Co.

FATHER
12. Name John H. Caves
13. Birthplace Va.

MOTHER
14. Maiden Name Pearl Ethel Martin
15. Birthplace Va.

16 (a) Informant: Mr. John H. Caves
(b) Address 1326 Pontiac Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/12/48

(c) Cemetery or crematory
Location Buckley, W. Va.

18 (a) Funeral director Wm. T. Tickner & Sons
(b) Address Balto, Md.

19 (a) Apr 10 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1948, at 5:30a.m.

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractures base of skull
Intracranial Hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following 4-01

(a) Date of injury 4-10-48 at 2:00 A.M.
(b) Where did injury occur? Lombardo Hanover Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? public place Why? no
(d) Means of injury Auto - Auto Collision

23. Signature Howard J. Madeira M.D.
Medical Examiner.

Date signed 4-10-48

062114

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

Registered No. 062114

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Ashburton Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Towson (If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 Loch Shiel Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES RAE VARIAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife: Mabel B. Varian
6 (c) If alive, give age: years

7. Birth date of deceased mo., day, yr: Dec. 8, 1873

8. AGE: Years	Months	Days	If less than one day
74	4	1	hr. min.

9. Birthplace: New York, N. Y. (Town, county and state)
10. Usual Occupation: Retired
11. Industry or business

FATHER
12. Name: Charles R. Varian
13. Birthplace: N. Y.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant: Mrs. Rae V. Shaw
(b) Address: 1813 Loch Shiel Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/12/48 (month) (day) (year)
(c) Cemetery or crematory: Friends
Location: Lansborne, Pa.

18 (a) Funeral director: W. J. TICKNER & SONS, INC.
(b) Address: Balto. Md.

19 (a) APR 10 1948 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1948 at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8 1941 to April 9 1948 and that I last saw him alive on April 9 1948.

Immediate cause of death	Duration
Cardio-renal-Vascular Disease	7yrs
Due to Myocardial Insufficiency	3 day
Due to	
Other Conditions (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work)
(e) Means of injury

23. Signature J. H. Wilson M. D.
Address 617 W. 40th St. Date signed 4/10/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

662115 ✓ 107

Registered No. 662115

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Also correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Cockeysville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ashland Road
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** Ronald Bennett

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex: Male | 5. Color or race: White | 6. (a) Single, married, widowed, or divorced: .....

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased: mo. ..... day ..... yr .....

8. AGE: Years ..... Months ..... Days 4 If less than one day: hr ..... min .....

9. Birthplace: Md. (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER
12. Name Austin Bennett
13. Birthplace Md.

MOTHER
14. Maiden Name Margery Wilson
15. Birthplace Md

16 (a) Informant .....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 12 48 (month) (day) (year)
(c) Cemetery or crematory Gorsuch
Location Sparks

18 (a) Funeral director S. M. Brooks
(b) Address Sparks, Md

APR 21 1948 (b) .....
(Date received by registrar) Registrar

VS 99

MEDICAL CERTIFICATION

20. DATE OF DEATH April - 10 - 1948, at 4 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from ..... 19 .... to ..... 19 ....
and that I last saw h..... alive on ..... 19 .....

Immediate cause of death: Lobular Pneumonia — Duration .....

Due to .....

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy Lobular Pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature J. H. H. M. D.
Address .....
Date signed 4-10-48

X

C62116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. C62116

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 dys
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 605 Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Boswell S Edwards
3 (b) If veteran, name war
3 (c) Social Security Account No
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary Mizelle Edwards
6 (c) If alive, give age years
7. Birth date of deceased: mo., day, yr 11-9-[illegible]
8. AGE: Years 68 | Months 4 | Days 21 | If less than one day: hr min
9. Birthplace: Smithfield Va. (Town, county, and state)
10. Usual Occupation: House Manager
11. Industry or business: 101 W. Lexington St

FATHER
12. Name: not obtainable
13. Birthplace

MOTHER
14. Maiden Name: not obtainable
15. Birthplace

16 (a) Informant: Mrs Biswell S. Edwards
(b) Address: 605 Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/48 (month) (day) (year)
(c) Cemetery or crematory Wallace Plot
Location Jamesville, N. C.

18 (a) Funeral director H. H. Ufford and Son
(b) Address 805 W. Calvert St.

19 (a) Date received by registrar 1948 (b) Registrar

VS 193

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 April 1948, at 5 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 30 March 1948, to 10 April 1948, and that I last saw h[illegible] alive on 10 April 1948.

Immediate cause of death
Due to: Post Operative Atelectasis
Due to: Vomiting from Gastritis
Due to: Dehydration and Electrolyte Imbalance

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9 April 48

Major findings of operation: Gastric Carcinoma ? Cancer

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. P. Freeman M.D.
Address Maryland Gen'l Hosp Date signed 13 Apr 48

X

G62117 — 48-02992

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓157E

G62117

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Data correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH: Sinai Hospital
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3415 Menlo Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROCHELLE LYNN Pondfield

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Feb 12, 1948

8. AGE: Years	Months	Days	If less than one day
	1	28	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name Jack Pondfield
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Selma Amernick
15. Birthplace Baltimore Md

16 (a) Informant Mrs Louis Pondfield
(b) Address 3605 Labyrinth Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April, 1 1948 (month) (day) (year)
(c) Cemetery or crematory Sharrei Zion Cemetery
Location Hamilton Ave Rosedale

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

APR 21 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1948 at 2.20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 7, 1948 to April 9, 1948 and that I last saw her alive on April 9, 1948

Immediate cause of death: Circulatory failure — Duration: over

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Circulatory failure

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Edward Kuhn M D
Address Sinai Date signed 4-9-48

VS 150

X

62118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

62118

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Cross out words not applicable. Date of birth and age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins Ave & Caton Ave
(c) Hospital or institution: St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Elmhurst Sta. Severn Md. R.F.D.
(If outside city or town limits, write RURAL and name town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife: none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 13, 47

8. AGE: Years	Months	Days	If less than one day: hr	min
0	5	26		

9. Birthplace Bayone, N.J. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Jesse D. Mitchell Jr.

13. Birthplace Elmhurst Station A.A.Co.

MOTHER 14. Maiden Name Doris C. Mahoney

15. Birthplace Bayone, N.J.

16 (a) Informant Mrs Doris Mitchell

(b) Address Elmhurst, Sta. Severn, Md. R.F.D.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 12, 48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Md.

18 (a) Funeral director Thomas W. Singleton

(b) Address Glen Burnie, Md.

19 (a) Apr 11 1948 (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 April 1948 at 4:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8 April 1948 to 9 April 1948 and that I last saw h / him alive on 9 April 1948.

Immediate cause of death	Duration
Surgical Shock	
Due to Craniotomy Rt.	
Due to Internal Hydrocephalus	

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9 April 48

Major findings of operation: Internal Hydrocephalus

of autopsy Same 9 April 48

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. E. Gatch M.D. M. D

Address Gltg Nas Hosp Date signed 9 April 48

Col- 662119

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

832a

662119
Registered No. 4560 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 15th

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1326½ N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Betty Mae Dell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased: mo., day, yr. 6-20-1919

8. AGE: Years 28 | Months 9 | Days 19 | If less than one day: hr. min.

9. Birthplace: Md; Baltimore
(Town, county, and state)

10. Usual Occupation: Telephone Co. Emp.

11. Industry or business:

FATHER 12. Name: Sherman Weaver

13. Birthplace: Md

MOTHER 14. Maiden Name: Mabel Cooper

15. Birthplace: N. C.

16 (a) Informant: Mrs. Mabel Weaver

(b) Address: 1326½ N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: April 3 1948 (month) (day) (year)

(c) Cemetery or crematory: Mt. Calvary

Location: Baltimore, Md.

18 (a) Funeral director: Mrs. Lew. H. Holland

(b) Address: 1681 Druid Hill Ave

APR 11 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-4-1948 at 6.00 a M

21. I certify that death occurred on the date above stated, that I attended deceased from 3-31-1948 to 4-4-1948 and that I last saw her alive on 4-4-1948.

Immediate cause of death: Subarachnoid Hemorrhage ? Ruptured Aneurysm

Duration: 2 weeks

Due to: Congenital cerebral aneurysm

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: David Krol, M. D.

Address: J H H Date signed: April 9 1948

VS 153

Bl. 662120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 662120

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2229 (Madison) Ave
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2229 (Madison) Ave. (If rural, give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Phillip William Malcum

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-16-9478

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Florinda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22, 1894

8. AGE: Years 53 | Months 11 | Days 16 | If less than one day: hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business:

FATHER
12. Name: Stephen Malcum
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Susan Morris
15. Birthplace: Virginia

16 (a) Informant: Mrs. Florinda Malcum
(b) Address 2229 Pennsylvania Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Maryland

18 (a) Funeral director Mrs. Lee V. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) Date received by Registrar April 9, 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-8-1948 3:50 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from 3/27/48 to 4/8/48 and that I last saw him alive on 4/8/1948.

Immediate cause of death: (a) Lobar Pneumonia — Duration: 4 days
Due to: (b) Bronchitis — 30 days
Due to: (c)
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Geo. R. Blake, M.D.
Address 1603-N Caroline St. (Date signed) 4-9-48.

VS 150

GG2121 GG2121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146F

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2331 Madison Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2331 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James H. Peters

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-05-0478

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Caroline Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1901

8. AGE: Years 46 | Months 6 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER 12. Name Charles Peters

13. Birthplace Baltimore, Md

MOTHER 14. Maiden Name Julia Stevens

15. Birthplace Westminster, Md

16 (a) Informant Mrs. C. Elizabeth Peters

(b) Address 2331 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12, 1948 (Month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mrs. George A. Holland

(b) Address 1631 Druid Hill Ave

19 (a) Apr 3 1948 (Date received by registrar) (b) Registered

Huntington Indiana

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1948 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from November 1947 to April 8 1948 and that I last saw h alive on April 8 1948.

Immediate cause of death Coronary Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maynard H. Jones

Address 1300 N. Broadway Date signed 4/10/48

VS 150

4/10/48

C62122

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

C62122 Registered No. 172349

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Talbot Co
(c) City or town St Michaels
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Robert C. Dodson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased: mo. 5 day 10 yr 09

8. AGE: Years	Months	Days	If less than one day: hr	min
38	11			

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Life Insurance
11. Industry or business

FATHER
12. Name Robert L. Dodson
13. Birthplace Tna

MOTHER
14. Maiden Name Ethel Mathews
15. Birthplace Md

16 (a) Informant:
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation or removal) (b) Date thereof April 13/48 (month) (day) (year)
(c) Cemetery or crematory Christ Church Cemetery
Location St Michaels Md.

18 (a) Funeral director John D. Mitchell & Son
(b) Address 1900 Eutaw Place,

19 (a) APR 1 1948 (b) Date filed by registrar Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-10 1948, at 5:35 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 3-14 1948 to 4-10 1948, and that I last saw him alive on 4-10 1948

Immediate cause of death Uremia — Duration

Due to Hypertensive cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Warren T. Vaughan M.D.

Address 600 N Hopkins Pkwy Date signed 4-10-48

G62123

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

G62123
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 812 Regester Ave.
(c) Hospital or institution: Armacost Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4330 Roland Court (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Emma C. Henderson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. October 20, 1866

8. AGE: Years	Months	Days	If less than one day
81	5	21	hr. min

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation retired schoolteacher
11. Industry or business

FATHER
12. Name Thomas Henderson
13. Birthplace Belfast, Ireland

MOTHER
14. Maiden Name Sarah Barron
15. Birthplace Belfast, Ireland

16 (a) Informant Ella Dunn
(b) Address 4330 Roland Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) 4/15/48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1948, at 2:30 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 1 1945 to April 10 1948 and that I last saw him alive on April 8 1948

Immediate Cause of death: Bronchial Pneumonia — Duration 4 days
Due to Senility
Due to Diabetes mellitus over long period
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature P L Kuyas M. D.
Address Wentworth Arms Apts. Date signed 4/10/48

VS (9)

G62124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G62124

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla (b) County
(c) City or town N. St. Petersburg (If outside city or town limits, write RURAL and give town)
(d) Street No. 804 Fourth Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ann Woodworth

3 (b) If veteran, name war — 3 (c) Social Security Account No

4. Sex: Female — 5. Color or race: White — 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Walter

6 (c) If alive, give age: 72 years

7. Birth date of deceased: mo., day, yr. 10-9-75

8. AGE: Years 72 Months Days 1 If less than one day: hr. min.

9. Birthplace N.Y. (Town, county and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER — 12. Name: Joseph Vinton

13. Birthplace: Ireland

MOTHER — 14. Maiden Name: Jennie

15. Birthplace: England

16 (a) Informant: Records

(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12/48 (month) (day) (year)

(c) Cemetery or crematory: Phoenix N.Y.

Location: Phoenix N.Y.

18 (a) Funeral director: John D. Mitchell Son

(b) Address: 1900 Eutaw Place

19 (a) (b)
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1948 at 2 35 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from 3-24-1948 to 4-10-1948 and that I last saw h alive on 4-10-1948

Immediate cause of death: Peritonitis — Duration: 9 hrs.

Due to: Carcinoma of Rectum — ?

Due to:

Other Conditions: Cholecystitis, Cholelithiasis

(Include pregnancy within 3 months of death)

Date of operation 4/7/48

Major findings of operation: Above

Findings of autopsy: Peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury Richard E. [illegible]

23. Signature [illegible]

Address Johns Hopkins Hosp. Date signed 4-10-48

VS 150

G62125 448089

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓48a

G62125 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Wyoming, (If outside city or town limits, write RURAL and give town)
(d) Street No. 253 Pettibond, St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura MacMillan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	married

6 (b) Name of husband or wife Olds MacMillan
6 (c) If alive, give age ? years

7. Birth date of deceased mo., day, yr. 7-6-92

8. AGE: Years	Months	Days	If less than one day
55	9	5	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name John W. Breese,
13. Birthplace Pa.

MOTHER
14. Maiden Name Kath Thomas
15. Birthplace Wales

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/11/48 (month) (day) (year)
(c) Cemetery or crematory West Pittston
Location Luzerne Co Pa

18 (a) Funeral director Pickett Funeral Home
(b) Address 200 E Orleans St

APR 1 1948 (Date rec'd by registrar) Huntington, W. Va. (Registrar)

VS 152

MEDICAL CERTIFICATION

20. DATE OF DEATH April - 11 - 1948 at 4 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-23-1948 to 4-11-1948 and that I last saw her alive on 4-11-1948.

Immediate cause of death Uraemia due to Hydronephrosis due to Obstruction of Ureter

Due to Carcinoma of Bladder

Due to Carcinoma of Cervix Uteri

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Absent

Duration
1 mo
?
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature Howard [illegible] M. D.
Address J.H.H. Date signed 4-11-48

C62126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

Registered No. C62126

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2900 W. LANVALE ST.
(c) Hospital or institution: 16-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 WKS

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County Balto.
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2810 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MICHAEL McCLELAN HOCK

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NO

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWED

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3/3/1868

8. AGE: Years	Months	Days	If less than one day
80	1	9	hr. min.

9. Birthplace HANCOCK, MD. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name SAMUEL HOCK
13. Birthplace ?

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant MRS. TAULINE M. SMITH
(b) Address 2900 W LANVALE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/14/48 (month) (day) (year)
(c) Cemetery or crematory DUNKARD CEM.
Location HANCOCK, MD.

18 (a) Funeral director CHAS. R. BAST
(b) Address HANCOCK. MD.

19 (a) APR 12 1948 (Date rec'd by registrar) (b) Huntington for Williams M.D. (Registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 11 1948, at 8P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 23 1948, to Apr 4 1948, and that I last saw him alive on April 4 1948.

Immediate cause of death	Duration
Myocarditis,	6m
Due to Arteriosclerosis	10y
Due to arthritis	5
Other Conditions none	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. S. French M. D.
Address 2324 Aisquith St Date signed 4/14/48

062127

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 062127

49a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 20-4
(b) Street address
(c) Hospital or institution: West Baltimore [illegible] hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 44 - [illegible] (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Burger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Chas P. Burger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 7th 1876

8. AGE: Years	Months	Days	If less than one day
71	7	4	hr. min.

9. Birthplace Balto. Co. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Self

FATHER
12. Name Wm Templer
13. Birthplace Md.

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Earl R. Burger
(b) Address 44 S. Franklintown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location " Md.

18 (a) Funeral director William Cook Inc
(b) Address 1367 St. Paul St.

19 (a) APR 12 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1948 at 5:45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 27, 1948 to April 11 1948, and that I last saw h-r alive on April 10 1948.

Immediate cause of death [illegible]

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7 (illegible) 47

Major findings of operation: [illegible] ABDOMINAL [illegible]

of autopsy: [illegible]

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Truman W. Checkett M.D.
Address WBGH Date signed 4/11/48

VS 150

062128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

062128 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2025 W. Fayette St.

(c) Hospital or institution: Bon Secours Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 48 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2258 Sidney Ave. - Balto. 30 (If rural, give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Bertha Lee Thompson

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Charles O.

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) April 23rd 1900

8. AGE: Years 47 | Months 11 | Days 16 | If less than one day: hr ____ min ____

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Theodore Moss Berger

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Elizabeth Dove

15. Birthplace Va.

16 (a) Informant Chas. O. Thompson

(b) Address 2255 Sidney Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/48 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

19 (a) APR 12 1948 (Date received by registrar) Huntington Williamsport

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-9 1948, at 7.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-8 1948 to 4-9 1948, and that I last saw h[illegible] alive on 4-9 1948.

Immediate cause of death Coronary Thrombosis — Duration ½ hour

Due to Congestive Heart Failure — Duration 6 mos.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home (or farm), industrial place, in public place? (While at work?)

(e) Means of injury

23. Signature Richard C. Hayden M. D.

Address Bon Secours Hosp. Date signed 4-9-48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

Registered No. G62129

G62129 48-016626

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Union Memorial Hospital 11-4

(d) Length of stay in hospital or inst. (~~yrs~~ ~~mos~~, or days) 21

(e) Length of stay in Baltimore (~~yrs~~ ~~mos~~, or days) 21

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County —

(c) City or town Baltimore 17 (If outside city or town limits, write (RURAL and give town))

(d) Street No. 1329 Linden ave (If rural give location)

(e) Citizen of foreign country? — (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Lee

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased, mo., day, yr. 3-22-48

8. AGE: Years 0 | Months 0 | Days 24 | If less than one day: hr. — min —

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Michael Francis Lee

13. Birthplace Maryland

MOTHER 14. Maiden Name Eleanor Hayes

15. Birthplace Maryland

16 (a) Interment Hospital Records

(b) Address —

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/13/48 (month) (day) (year)

(c) Cemetery or crematory St Michaels

Location Govanstown Md

18 (a) Funeral director Fulhorter & Poe

(b) Address 1219 Eutaw St

19 (a) APR 12 1948 (Date rec'd by registrar) (b) Registrar Huntington McClennan, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-11 1948 at 12 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-22 1948 to 4-11 1948, and that I last saw h alive on 4-11 1948.

Immediate cause of death Hydrocephalus internal — Duration: Life

Due to Block of aqueduct of Sylvius (encephalogram - done)

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at — M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?

(e) Means of injury —

23. Signature E B Chambers

Address Union Memorial Hosp

Date signed 4/11/48 M.D.

G62130

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 479

G62130
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3508 Clipper Rd
(c) Hospital or institution: 13-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3508 Clipper Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Samuel S. Hamilton
3 (b) If veteran, name war
3 (c) Social Security Account No. 215-07-6417

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Mainey E.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 9th 1875

8. AGE: Years	Months	Days	If less than one day: hr	min
72	4	1		

9. Birthplace Balto. Co. Md. (Town, county and state)
10. Usual Occupation Night Watchman
11. Industry or business Poole Engineering Co.

FATHER
12. Name John Hamilton
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Crawford
15. Birthplace Ireland

16 (a) Informant Mrs. Mainey E. Hamilton
(b) Address 3508 Clipper Rd.

17 (a) Burial (Burial, ~~cremation or removal~~) (b) Date thereof 4/13/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) APR 12 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10th 1948, at 1 15 P. M
21. I certify that death occurred on the date above stated, that I attended deceased from May 15 1947 to April 10 1948, and that I last saw h/M alive on April 10 1948.

Immediate cause of death	Duration
Myocardial degeneration	5 days
Due to Carcinomatosis	6 Months
Due to	
Other Conditions	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Arthur G. Davies. M D
Address 800 N 33rd St Date signed 4-10-48

VS 150

G62131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G62131

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 908 Druid Hill Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Williams
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife John H.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct.
8. AGE: Years 52 | Months 6 | Days | If less than one day: hr. min.
9. Birthplace Kent Co. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert Comegys
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Blake
15. Birthplace Md.

16 (a) Informant John H. Williams
(b) Address 908 Druid Hill Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-48 (month, day, year)
(c) Cemetery or crematory Mt. Calvary.
Location
18 (a) Funeral director A. A. Halstead
(b) Address 918 Druid Hill Ave
19 (a) APR 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/8/48 19 8:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury X at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John Edwards M.D.
Medical Examiner
Date signed

VS 181

C62132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 48a

Registered No. C62132

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Pk. Drive & 31st St.

(c) Hospital or institution: US Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days): 175 days

(e) Length of stay in Baltimore (yrs., mos., or days): 175 days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Florida (b) County:

(c) City or town: Coral Gables (If outside city or town limits, write RURAL and give town)

(d) Street No.: 1311 Capri St. (If rural give location)

(e) Citizen of foreign country? (Yes or No): no

If yes, name country:

3 (a) FULL NAME: ELLA SKELTON BROWNE

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: --

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harvey S. Browne

6 (c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): Dec. 4, 1895

8. AGE: Years: 54 Months: 3 Days: 4[illegible] If less than one day: hr. min.

9. Birthplace: Key West, Florida (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Thomas Skelton

13. Birthplace: Key West, Florida

MOTHER — 14. Maiden Name: Adella Knowles

15. Birthplace: Key West, Florida

16 (a) Informant: Records

(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal)

(b) Date thereof: 4/12/48 (month, day, year)

(c) Cemetery or crematory: Arlington National

Location: Arlington, Va.

18 (a) Funeral director: HENRY SANDER & SONS, INC.

(b) Address: NORTH AVE. & BROADWAY

19 (a) APR 12 1948 (Date received by registrar) Huntington Indiana Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8 1948, at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 1947 to Apr. 8 1948. and that I last saw her alive on Apr. 8 1948.

Immediate cause of death: Carcinoma of cervix with local extension — Duration: 14 mos.

Other conditions: Anemia due to chronic loss of blood — Duration: 4 wks.

Other Conditions: Uremia — Duration: 1 wk.

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)

(e) Means of injury:

23. Signature: John L. Wilson

John L. Wilson, Sr. Surgeon

Address: Clinical Director Date signed: 4/9/48 M.D.

VS 1[illegible]

G62133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G62133

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. CAROLINE ST.

(c) Hospital or institution: ST. JOSEPH'S HOSPITAL 8-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 DAY

(e) Length of stay in Baltimore (yrs., mos., or days) 69 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County —

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 2250 E. NORTH AVE (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME ELIZABETH SCHEUERMAN (Barbara Elizabeth Scheuerman)

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: Louis Scheuerman

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr): 12/1/59

8. AGE: Years: 88 Months: 4 Days: 8 If less than one day: hr. min.

9. Birthplace: FRANKFORT GERMANY (Town, county, and state)

10. Usual Occupation: NONE

11. Industry or business

FATHER 12. Name: Henry Maier

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden Name: Eva ?

MOTHER 15. Birthplace: Germany

16 (a) Informant: Mr. George Scheuerman

(b) Address: 2250 E. North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/48 (month) (day) (year)

(c) Cemetery or crematory: Holy Redeemer Cemetery

Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.

(b) Address: NORTH AVE. & BROADWAY

19 APR 12 1948 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/9/48 19 , at 6 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/8/ 1948 to 4/9 1948.

and that I last saw him alive on 4/9 1948.

Immediate cause of death: CARDIAC FAILURE — Duration

Due to ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE

Due to

Other Conditions: ① HYPERTENSION ESSENTIAL ② CARDIAC ASTHMA

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: Henry J. Hourihan

Address: St. Joseph's Hosp. Date signed: 4/9/48

V S 150

G62134

48-07096

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 159

G62134
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Turners (If outside city or town limits, write RURAL and give town)
(d) Street No. 3 [illegible] Ave (If rural give location)
(e) Citizen of foreign country? [illegible] (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy Dittmar

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	WHITE	single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible]

8. AGE: Years	Months	Days	If less than one day
			6 hr [illegible] min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business —

FATHER
12. Name Edward Jacob Dittmar
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Anita Eleanor Arndt
15. Birthplace Sykesville, Md.

16 (a) Informant Mrs. Anita Dittmar
(b) Address 3 [illegible] Ave, Turners, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School APR 7, 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) APR 12 1946 (b) Thaddeus [illegible] Williams, M.D.
(Date rec'd by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1946, at 7:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 4/1/1946 to 4/1/1946, and that I last saw him alive on 4/1/1946.

Immediate cause of death: Hemorrhage Liver — Duration
Due to Fractured Skull Est. duration 2 hrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 4-3-46

X

C62135

BC-48-07863

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 160a

C62135
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood + Frane Sts.
(c) Hospital or institution: University md. Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Patapsco (If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Knouse

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	newborn

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-2-48

8. AGE: Years	Months	Days	If less than one day
			8 hr. 2 min.

9. Birthplace Baltimore (Balt.) Md. (Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business Farmer

FATHER
12. Name John Edgar Knouse
13. Birthplace Patapsco, Md.

MOTHER
14. Maiden Name Virginia Ruth Schaffer
15. Birthplace Hampstead, Md.

16 (a) Informant Mother
(b) Address Patapsco, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School APR 8, 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) APR 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-3 1948 at 12:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-2 1948 to 4-3 1948 and that I last saw her alive on 4-3 1948.

Immediate cause of death	Duration
Cerebral Anoxia	
Due to Pulmonary Hemorrhage	
Due to Birth Trauma	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. E. Conley Jr.
Address Maryland Md. Hosp. Date signed 4-3-48

VS 150

C62138 Fin
10
48-01860

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

C62136
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 17-3
(b) Street address 514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs 45 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 hrs. 45 min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore #1 (If outside city or town limits, write RURAL and give town)
(d) Street No. 831 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Matthews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: N | 6 (a) Single, married, widowed, or divorced:

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-26-48

8. AGE: Years | Months | Days | If less than one day: 3 hr. 45 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Thomas Purvinas
13. Birthplace Towson, Md.

MOTHER
14. Maiden Name Juanita Campbell
15. Birthplace Lawrenceburg, N. C.

16 (a) Informant Juanita Matthews
(b) Address 831 W. Franklin St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School APR 5, 1948
18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) APR 12 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26 1948, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-26 1948, to 3-26 1948, and that I last saw him alive on 3-26 1948

Immediate cause of death: Prematurity (24 hrs)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Lutherville Md. Date signed 3-27-48

VS 150

662137

48-04752

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 157E

Registered No. 662137

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6 Monument St
(c) Hospital or institution: Sinai Hosp 15-17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 1/2 hr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto - Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2446 Shirley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Kandel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	WH	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 3 - 1947

8. AGE: Years	Months	Days	If less than one day
NB			1 hr. 25 min.

9. Birthplace Balto - Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Kerman Kandel
13. Birthplace Balto - Md

MOTHER
14. Maiden Name Dorothy Frank
15. Birthplace Balto - Md

16 (a) Informant Dorothy Kandel
(b) Address 2446 Shirley Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School APR-5 1948

18 (a) Funeral director Commissioner of Health
(b) Address APR 12 1948 Hamilton Williams, M.D.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 3 1948 19 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/3 1948 to 3/3 1948.
and that I last saw [illegible] alive on 3/3 1948.

Immediate cause of death Respiratory failure
Due to Atelectasis
Due to Congestion of lungs
Other Conditions Patent Foramen Ovale & Ductus Botalo
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Katz, M.D.
Address Sinai Hospital Date signed 4/5/48

1612

C62138

FC- 03389

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157E

Registered No. C62138

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2 Monument St
(c) Hospital or institution: Mercy 8-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da
(e) Length of stay in Baltimore (yrs., mos., or days) 6 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1641 N Bond Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Branham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: Wht

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16 - 1948

8. AGE: Years: NB | Months | Days: 6 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Geo. W. Branham Sr.
13. Birthplace ~~Md~~ Va.

MOTHER
14. Maiden Name Dorothy V. Dellot
15. Birthplace Balto Md

16 (a) Informant Dorothy V. Branham
(b) Address 1641 N Bond St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School APR 5, 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

APR 12 1948

19 (a) (Date rec'd by registrar) (b) [illegible] Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1948 to Feb 22 1948 and that I last saw her alive on Feb 22 1948.

Immediate cause of death	Duration
Hepatic failure	
Due to Congenital defect of Heart	
Due to Congenital	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Congenital anomaly of heart

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address Kauai Hospital Date signed 4/3/48

C62139

48-07012

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. C62139

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun St Franklin Square Hosp
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) — 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2341 Sidney Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Sonnenleiter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1948

8. AGE: Years | Months | Days | If less than one day 3 hr min

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation newborn

11. Industry or business

FATHER
12. Name Donald Henry Sonnenleiter
13. Birthplace Balto Md

MOTHER
14. Maiden Name Ruth Frances Dalziel
15. Birthplace Balto, Md

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location [illegible] Medical School APR 6, 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (Date rec'd by registrar) APR 12 1948 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1948, at 7:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-2 1948, to 4-2 1948, and that I last saw him alive on 4-2 1948.

Immediate cause of death

Due to

Due to

Other Conditions premature (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address [illegible] Date signed 4/3/48

VS 180

062140

GN. 80842

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH . 13B

Registered No. 062140

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 7 6 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 1614 Druid Hill Ave
(d) Street No. Y.M.C.A. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Russell Holmes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Sep.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April -1 -1908

8. AGE: Years	Months	Days	If less than one day
40	-	8	hr. min.

9. Birthplace MD. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert Holmes (D)
13. Birthplace MD.

MOTHER
14. Maiden Name Alice (D)
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md.

18 (a) Funeral director Francis A. Dempsey
(b) Address 578 W. Biddle St.

19 (a) APR 12 1948 (Date received by registrar) (b) Transit for Alabama, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4- 9- 19 48 at 7.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4 - 8- 19 48. to 4- 9- 19 48. and that I last saw him alive on 4 - 9- 1948.

Immediate cause of death Pulmonary tuberculosis, rt upper lobe

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Vinbury Jr. M.D.
Address Balto City Hosp. Date signed 10 April 48.

VS 150

X

C62141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC-48-06941 159

X ✓ C62141

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 7 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne [illegible]
(c) City or town Glen Burnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. Wilson Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Burch
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced S
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)
8. AGE: Years 0 Months 0 Days 0 If less than one day 7 hr 24 min
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Charles Bowman Burch
13. Birthplace Coal City, Va.

MOTHER
14. Maiden Name Mary Middlebrooks
15. Birthplace Caroline City, Va.

16 (a) Informant Mother
(b) Address Glen Burnie, Md

17 (a) (Burial, cremation, or removal)
(b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School 2, 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) APR 12 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Mar 19 48, at 6:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 30 Mar 19 48, to 30 Mar 19 48, and that I last saw h[illegible] alive on 30 Mar 19 48

Immediate cause of death: Congenital atelectasis — Duration

Due to prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation April 1, 1948

Major findings of operation:

of autopsy Congenital atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert T. Schoenbachler
Address Maryland General Hospital Date signed 2 Apr 48 M D

VS 150

C62142

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 121 B

Registered No. C62142

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13-3
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2744 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lelia Green
3 (b) If veteran, name war
3 (c) Social Security Account No
4 Sex female
5 Color or race Colored
6 (a) Single, married, widowed, or divorced Sep.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased mo day yr 4-1-10
8. AGE: Years 37 Months ? Days If less than one day hr min
9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward Walker
13. Birthplace Canada

MOTHER
14. Maiden Name Martha Meadows
15. Birthplace Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City
18 (a) Funeral director Wm A Jackson
(b) Address 916 Penna Ave
19 (a) (Date received by registrar) APR 12 1948 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1948 at 12 45 M
21. I certify that death occurred on the date above stated, that I attended deceased from 3/25 1948 to 4/9 1948 and that I last saw him alive on 4/9 1948

Immediate cause of death: Uremia — Duration 6 mos
Due to: chronic glomerulo-nephritis — Duration yrs
Due to:
Other Conditions
(Include pregnancy within three months of death)
Date of operation
Major findings of operation:
of autopsy: Labor

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. S. Sipson
Address Johns Hopkins Hosp. Date signed 9 April 48

T

062143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 062143

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 635 Mosher St

(c) Hospital or institution: 14-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 635 Mosher St (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) **FULL NAME** Mamie Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Ashley Hill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. **AGE:** Years 38 | Months 7 | Days 12 | If less than one day hr. min.

9. Birthplace Balto. Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name William Porter

13. Birthplace Maryland

MOTHER

14. Maiden Name Laura Owens

15. Birthplace Maryland

16 (a) Informant Ella Babb

(b) Address 1524 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-48 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Park

Location Arbutus

18 (a) Funeral director Rayner Sanders

(b) Address 1412 E Preston St

19 (a) APR 12 1948 (Date received by registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. **DATE OF DEATH** 4-8 1948, at 10 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 3-25 1948 to 4-8 1948 and that I last saw h[illegible]ive on 4-7 1948.

Immediate cause of death Uremia

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature B. Z. Hale

Address 1725 Park Ave Date signed 4/9/48

V S 150

062147 Mary Amelia

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 062144

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert St.

(c) Hospital or institution: Union Memorial Hosp. Inl

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:

a State Md. b County HARFORD

c City or town Fallston (If outside city or town limits, write RURAL and give town)

d Street No. (If rural give location)

e Citizen of foreign country? No Yes or No

If yes, name country

3 (a) **FULL NAME** Mrs. Joseph S. Archer MARY AMELIA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16 1877

8. AGE: Years: 70 Months: 10 Days: 11 If less than one day: hr. min. 0

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation O

11. Industry or business

FATHER 12. Name Hudson Bateman

13. Birthplace Maryland

MOTHER 14. Maiden Name Mary A. Stabilford

15. Birthplace Maryland

16 (a) Informant Son - Raymond B. Archer

b Address Fallston Md.

17 (a) Burial (Burial, cremation, or removal) b Date thereof (month, day, year) Apr. 13-48

c Cemetery or crematory Union Chapel Cemetery

Location Joppa Md

18 (a) Funeral director West Archer

b Address Benson Md

19 (Date received by registrar) APR 12 1948 Huntington Williams Mgr

VS 190

MEDICAL CERTIFICATION

20. **DATE OF DEATH** April 11 1948 at 11 25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1948 to April 11 1948 and that I last saw her alive on April 11 1948.

Immediate cause of death	Duration
broncho pneumonia	4 days.
Due to cardiac decompensation	8 days
Due to	
Other Conditions diabetes mellitus	6 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

a Accident, suicide, or homicide

b Date of occurrence at M

c Where did injury occur? (City or town) (County) (State)

d Did injury occur about home, on farm, industrial place, in public place? (Specify) (Where at work?)

e Means of injury

23. Signature Samuel V. Taylor M.D.

Address Union Memorial Hosp. Date signed 4/12/48

9-c

662145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30

Registered No. 662145

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University 17-V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 Pennsylvania Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Archer Alba Gibbs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	B	

6 (b) Name of husband or wife Viola

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr

8. AGE: Years	Months	Days	If less than one day: hr	min.
68				

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name ? Unknown
13. Birthplace

MOTHER
14. Maiden Name ? Unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School APR 6, 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) APR 12 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 30 1948, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3 26 1948, to 3 30 1948, and that I last saw him alive on 3 30 1948

Immediate cause of death: Resp. failure — Duration

Due to Pneumonia, lobar

Due to Emphysema & arteriosclerosis.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C B Mayhew M D

Address Univ. Hosp. Date signed 3 31 48

VS 189

G62146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G62146 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4-1
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 426 W. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Franklin Terry

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School APR 9, 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) APR 12 1948 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1948, at 5:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection and Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-vascular Disease.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mellis M.D.
Medical Examiner
Date signed 4-3-48

G62147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G62147

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. Route 14, Box 632 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Jones (Preston)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days: 2 | If less than one day: hr min

9. Birthplace Balto. Co. Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Rosie Jones

13. Birthplace ?

MOTHER 14. Maiden Name Calvin Preston

15. Birthplace ?

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month)

(c) Cemetery or crematory

Location University Medical School APR 5, 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) APR 12 1948 (Local registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH 3-26- 1948, at 1 M

21. I certify that I took charge of the remains described above, held an Inspection and Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Prematurity
Ateleotasis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 3-27-48

C62148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. C62148

JL - 94280

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 26-17

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Unknown (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maggie Sanders

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr ? ? ?

8. AGE: Years 57 ? Months Days If less than one day hr min

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Byrd Cheeks

13 Birthplace ?

MOTHER 14. Maiden Name Dianna Burroughs

15 Birthplace N. C.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School 8, 1948

Commissioner of Health

18 (a) Funeral director

(b) Address

19 (a) APR 12 1948 (b) Huntington Williams, M.D. Registrar

(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1948, at 8.45AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1945 to March 27 1948, and that I last saw her alive on March 27 1948.

Immediate cause of death: Bronchopneumonia Right lower lobe.

Duration

Due to

Due to

Other Conditions Hyperpyrexia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature William H Neuhaus Jr. M.D.

Address Balt City Hosp Date signed 5/8/48.

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G62149

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

Registered No. G62149

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 3-2
(b) Street address
(c) Hospital or institution: Johns Hop. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 811 E. Balto. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James RILEY

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day: hr. min.
55			

9. Birthplace Unknown
(Town, county and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School APR 5, 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) APR 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25/1948, at 8:25 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Lobar pneumonia
Fatty degeneration of liver
Due to
Other Conditions Chronic alcoholism.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 3/25/48

VS 151

G62150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63B

G62150

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp. 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1529 McCulloh
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie BARNES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Col.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr	min
49				

9. Birthplace Unknown
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School APR 5, 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) APR 12 1948 (b) [illegible] Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25 1948 at 10 VS AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Toxic adenoma of thyroid.
Acute congestive cardiac failure

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner
Date signed 3/25/48

VS 151

G62151 48-07474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G62151 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1928 Harlem Ave
(c) Hospital or institution: 16-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 36 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1928 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? 2nd (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Fauntleroy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1948

8. AGE: Years | Months | Days | If less than one day: 3½ hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Carlwin Fauntleroy
13. Birthplace Conn.

MOTHER
14. Maiden Name Grace Ivory
15. Birthplace Conn.

16 (a) Informant Grace Fauntleroy
(b) Address Conn.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School APR 6, 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) APR 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1948, at 3 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-3- 1948 to 4-5- 1948, and that I last saw h alive on April 5 1948.

Immediate cause of death ~~Fauntleroy~~ — Duration: 5 Min

Due to Prematurity & Cyanosis —

Due to Unknown —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 723 Druid Hill Ave Date signed

VS 150

X 4-6-48

C62152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. C62152

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3647 Cottage Ave

(c) Hospital or institution: 15-12

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 45yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3647 Cottage ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Jacob Greenberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 73 Months: Days: If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER 12. Name: Yudah

13. Birthplace: Russia

MOTHER 14. Maiden Name: Not Known

15. Birthplace: Russia

16 (a) Informant: Lillian Greenberg

(b) Address: 3647 Cottage ave

17 (a) Burial (cremation, or removal)

(b) Date thereof: 4-12-48 (month) (day) (year)

(c) Cemetery or crematory: Arlington

Location: Rogers Ave

18 (a) Funeral director: Jack Lewis Inc

(b) Address: 2400 Eutaw Place

19. APR 12 1948 (Date rec'd by registrar) Huntington Williams Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-11-1948 at 7¼ M

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 19 to 4-11 1948.

and that I last saw h alive on 4/11/48 19

Immediate cause of death

Asthenoclerosis of Coronary arteries

Due to Thrombosis of Coronary arteries

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

?

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (While at work)

(e) Means of injury

23. Signature Nelson B Kunkel MD

Address 2370 Eutaw Pl Date signed 4/11/48

VS 150

94a

062153

AB-110668

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 062153

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 512 Stockton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Milton Scott

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 24-1921

8. AGE: Years	Months	Days	If less than one day
26	11	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Waterfront worker
11. Industry or business

FATHER
12. Name Joseph Scott
13. Birthplace Va.

MOTHER
14. Maiden Name Rebecca Green
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof 4 15 48 (month) (day) (year)
(c) Cemetery or crematory M. Auburn
Location Annapolis Rd.

18 (a) Funeral director Leonard Whalen
(b) Address 1047 Myrtle Ave.

19 (a) APR 12 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10- 1948, at 8.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-15- 1947, to 4-10- 1948, and that I last saw him alive on 4-10- 1948.

Immediate cause of death Bilateral pulmonary tuberculosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H Nuckols M.D.
Address Balt City Hosp Date signed 11 Apr 48

G62154

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

115c

Registered No. G62154

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1214 Eutaw Place 4-2
(c) Hospital or institution:
Baltimore Eye Ear and Throat Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hours
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 639 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Junior Mack

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 212-01-9069

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife Ida Lee Mack
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) June 5, 1899

8. AGE: Years	Months	Days	If less than one day
48	10	4	hr. ____ min.

9. Birthplace Columbus South Carolina (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Charles Mack
13. Birthplace South Carolina

MOTHER
14. Maiden Name Sarah Lowston
15. Birthplace South Carolina

16 (a) Informant Ida Lee Mack
(b) Address 639 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-14-48 (month) (day) (year)
(c) Cemetery or crematory Columbia S.C.
Location S. C.

18 (a) Funeral director George G. Kelson
(b) Address 1303 Presstman St

19 (a) APR 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Signature of registrar)
Wm C. Hellings, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1948 at 9:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 9 1948 to April 9 1948, and that I last saw him alive on April 9 1948.

Immediate cause of death
Anoxia

Due to Following after nitrous oxide anesthesia

Due to respiratory failure set in

Other Conditions Tonsillectomy + adenoidectomy. Chronic Tonsilitis.
(Interval between onset and death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 4/9/48 at 9 A.M.
(c) Where did injury occur? Eye Ear & Throat Hosp. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, or public place? Hosp. (Specify which) (While at Work) No
(e) Nature of injury Died on operating table-Nitrous oxide anesthesia

23. Signature Robert Brisbane Graves Jr. M.D.
Address 1219 Eutaw Place Date signed 4-9-48

G62155
AB-118954

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 149a

Registered No. G62155

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 37yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 414 East St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katherine Jones S3511

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife John E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept- 23- 1909

8. AGE: Years	Months	Days	If less than one day
38	6	15	hr min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Clarence Martin
13. Birthplace Md.

MOTHER
14. Maiden Name Stella Anderson
15. Birthplace Va.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 4-12-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director George R. Nelson
(b) Address 203 Pleasant St

19 (a) 4-8-48 (Date rec'd by registrar) (b) Huntington Williams (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8- 1948, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-7- 1948 to 4-8- 1948, and that I last saw her alive on 4-8- 1948.

Immediate cause of death Shock — Duration 1h 20 min

Due to Post Partum Hemorrhage — 17 hours

Due to Incomplete Rupture Uterus — 2

Other Conditions Multiparity

(Include pregnancy within 3 months of death)

Date of operation Sept. del. Rupt. Uterus

Major findings of operation:

of autopsy: Rupture 2 low uterine segment with Retained Placenta

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address City Hospital Date signed 4-8-48

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

662156

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

178c

Registered No. 662156

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: S. Balto. Gen'l. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County York
(c) City or town York (If outside city or town limits, write RURAL and give town)
(d) Street No. 323 E. Cottage Pl. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Melvin D. Nonemaker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	MARRIED

6 (b) Name of husband or wife MARY O.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6 1874

8. AGE: Years	Months	Days	If less than one day: hr.	min.
73	5	5		

9. Birthplace YORK, CO., PA. (Town, county and state)

10. Usual Occupation CARPENTER

11. Industry or business

FATHER
12. Name Wm. Nonemaker
13. Birthplace No RECORD

MOTHER
14. Maiden Name Laura Day
15. Birthplace No RECORD

16 (a) Informant John A. Hatwald Jr.
(b) Address York, Pa

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR. 12, 1948 (month, day, year)
(c) Cemetery or crematory MT. ROSE
Location YORK, PA.

18 (a) Funeral director Guy B. Crapster & Hatwald
(b) Address York, Pa

19 (a) APR 10 1948 (Date received by Registrar) (b) Huntington Williams, Md Registrar

VS 151

MEDICAL CERTIFICATION 4/10/48

20. DATE OF DEATH April 10, 1948, at 2:20 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said ~~Autopsy~~, Inspection or ~~Inquiry~~, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to Exhaust fumes, gasoline engine

Other Conditions

(Include pregnancy within three months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 2514 P.
(a) Date of injury April 10, 1948 2:20 P. M.
(b) Where did injury occur? Yacht "Walgean"
(c) Did injury occur at home, on farm, industrial place, in public place? No. Yacht Club (while at work?) Yes
(d) Means of injury Asphyxiation - exhaust fumes

23. Signature Howard J. Mencin M.D. Medical Examiner
Date signed 4-12-48

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G62157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G62157

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Baltimore
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Lorelmont
(If outside city or town limits, write RURAL and give town.)
(d) Street No. 4815 Poplar Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Homer I. Layman

3 (b) If veteran, name war: World War 1
3 (c) Social Security Account No. 212-05-0500

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Gladys N. Layman
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) June 12, 1895

8. AGE: Years	Months	Days	If less than one day: hr.	min.
52	9	17		

9. Birthplace Frostburg, Md.
(Town, county, and state)
10. Usual Occupation P.B.X. Repairman
11. Industry or business C & P Telephone Co.

FATHER
12. Name Jos Layman
13. Birthplace Allegheny Co. Md

MOTHER
14. Maiden Name Miss Moody
15. Birthplace Allegheny Co., Md.

16 (a) Informant Mrs. Gladys N. Layman
(b) Address 4815 Poplar Drive, Lorelmont

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 12, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Randallstown, Md.

18 (a) Funeral director C. Wallace Lamoreaux
(b) Address 4510 Liberty Heights Ave.

19 (a) APR 10 1948 (b) Huntington Williams M.D.
(Date received by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1948 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1946 to April 1948.
and that I last saw h[illegible] alive on April 9 1948.

Immediate cause of death Coronary Occlusion — Duration 5 mos.

Due to Hypertension Cardio Vas

Due to Renal

Other Conditions Nervous

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm Thos G Abbott M. D.
Address 4500 Liberty Heights Ave Date signed

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

BC-48-08289

662158

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 157M

Registered No. 662158

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Siani Hospital 2L-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3231 Romona Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Drusano

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr April 5, 1948

8. AGE: Years	Months	Days	If less than one day hr.	min.
		5		

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Louis L. Drusano
13. Birthplace ?

MOTHER
14. Maiden Name Marsella Ellemann
15. Birthplace ?

16 (a) Informant Louis L. Drusano
(b) Address 3231 Romona Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 12 48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Road

18 (a) Funeral director Lilly and Miller, Inc.
(b) Address 103 S. Wolfe St.

19 APR 12 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 1948 at 5:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 5, 1948 to April 10, 1948, and that I last saw h/m alive on April 10, 1948.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Pulmonary edema and congestion	
Due to	
Other Conditions Patent-auricular septal defect. (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy: not complete yet

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(e) Means of injury

23. Signature Stanley A. Steinberg M.D.
Address Siani Hospital Date signed 4/16/48

VS 150

111C

G62159

VONELLA ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

G62159 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 401 N. Carrollton

(c) Hospital or institution: Mercy Hosp — 20-3

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 dy

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2001 Dulton St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Violet Vonella

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife ? Joseph Vonella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 21 1901

8. AGE: Years	Months	Days	If less than one day
46	4	21	hr min

9. Birthplace Maryland (Town, county, and state) ?

10. Usual Occupation

11. Industry or business

FATHER

12. Name William Howard

13. Birthplace Md

MOTHER

14. Maiden Name Frances Hoffman

15. Birthplace Md

16 (a) Informant

(b) Address

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 4-13-48 (month) (day) (year)

(c) Cemetery or crematory Prospect Cem

Location Georgia Rd

18 (a) Funeral director John C. Malley Sons

(b) Address 2435 Huntington Ave, Baltimore, Md

APR 12 1948 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 11 1948, at 2A. M

21. I certify that death occurred on the date above stated, that I attended deceased from 23 March 1948 to 11 April 1948 and that I last saw her alive on 11 April 1948

Immediate cause of death: Cardiac Failure — Duration

Due to Portal Obstruction

Due to Liver Cirrhosis

Other Conditions: Ascites, Hydrothorax (Include pregnancy within 3 months of death)

Date of operation 4/5/48

Major findings of operation: Cirrhosis, Ascites

of autopsy: Irvin Cirrhosis Ascites

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Abigail K. Reynolds M.D.

Address 9 Park Ave Date signed 4/11/48

VS 180

G62160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G62160

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 21 S. CHAPEL ST.
(c) Hospital or institution: — 2-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County CITY
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 21 S. CHAPEL ST (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME BARBARA BACKOF

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 26 1876

8. AGE: Years	Months	Days	If less than one day
72	1	24	hr min

9. Birthplace BALTO. MD. (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business —

FATHER
12. Name GEORGE BACKOF
13. Birthplace GERMANY

MOTHER
14. Maiden Name KUNIGUNDA KEIN
15. Birthplace BALTO. MD.

16 (a) Informant MARY BACKOF
(b) Address 215 CHAPEL
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/13/48 (month) (day) (year)
(c) Cemetery or crematory HOLLY PENNEMER
Location BALTO. MD
18 (a) Funeral director HENRY W. JENKINS SONS CO INC.
(b) Address MC CULLOH & ORCHARD ST
19 (a) APR 12 1948 (Date rec'd by registrar) By [illegible] Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1948 at 6:35 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 12 1939 to April 9 1948, and that I last saw her alive on April 8 1948

Immediate cause of death	Duration
Congestive Heart Failure	2 days
Due to Cardio-Vascular Hypertensive Disease	9 years
Due to Arteriosclerosis	9 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Michael J. Dausch M.D.
Address 1 W. Overlea Ave Date signed 4/10/48

VS 150

X

062161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. 062161

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 15-9
(b) Street address 33rd & Calvert St
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32d.
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
a. State Md. b. County Balto City
c. City or town Baltimore (If outside city or town limits, write R.F.D. and give town)
d. Street No. 3712 Winterbourne Road (If rural, give location)
e. Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Frank Empson Pennock, Sr

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: W
6 (b) Name of husband or wife: Rowena Pennock
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) June 28, 1859

8. AGE: Years 88 | Months 9 | Days 12 | If less than one day: hr. ____ min ____

9. Birthplace New Jersey (Town, county, and state)

10. Usual Occupation Retired (Buyer)
11. Industry or business Dry Goods

FATHER
12. Name James Pennock
13. Birthplace New Jersey

MOTHER
14. Maiden Name Jeanette Keller
15. Birthplace New Jersey

16 (a) Informant Son Mr. Pennock Jr
(b) Address 3712 Winterbourne Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13-1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Balto Md

18 (a) Funeral director Bertram Hoffberger
(b) Address 2234 N. Charles St.

19 (a) Date received by registrar APR 12 1948 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1948, at 9:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/17 1948 to 4/10 1948 and that I last saw him alive on 4/10 1948.

Immediate cause of death: Cardiac Failure — Duration: ____

Due to: Arteriosclerotic Heart Disease

Due to: ____

Other Conditions: Generalized arteriosclerosis (Include pregnancy within 3 months of death)

Date of operation 3/12/48

Major findings of operation: Benign Prostatic Hypertrophy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide? No
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(e) Means of injury

23. Signature John N. Dorsey, M.D.
Address Union Memorial Hospital
Date signed 4/10/48

VS 199

662162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 662162

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1735 E. Lombard St
(c) Hospital or institution: 2-W

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1735 E. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wojciech George (Kipper) Kiper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Magdalina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day: hr	min.
76				

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Casimir Kiper
13. Birthplace Poland

MOTHER
14. Maiden Name Unk.
15. Birthplace Poland

16 (a) Informant Magdalina Kipers
(b) Address 1735 E Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 13/48 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore

18 (a) Funeral director Fred W. Ozazewski
(b) Address 1900 Eastern Ave

19 (a) APR 12 1948 (Date rec'd by registrar) Remington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/11 1948 at 1 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V disease

Due to

Other Conditions Bronchitis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. C. Lubenski M.D.
Medical Examiner

Date signed 4/11/48

VS 191

G62163

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 186a

Registered No. G62163

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct [illegible] is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 8/6
(a) Baltimore City, Maryland
(b) Street address LINDEN AVE AND MADISON ST
(c) Hospital or institution: MARYLAND GENERAL HOS.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2048 E. FEDERAL ST. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH SCHULTZ
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	W	WIDOWED

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr 6/16/67

8. AGE: Years	Months	Days	If less than one day hr	min
80 81	2	20		

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name JOSEPH BOSKY
13. Birthplace

MOTHER
14. Maiden Name ROSE SCHELLAGER
15. Birthplace

16 (a) Informant MRS. JOSEPH MILCHING
(b) Address 2048 E. FEDERAL ST

17 (a) ~~Auto~~ Burial (Burial, cremation, or removal) (b) Date thereof April 13 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem City
Location

18 (a) Funeral director Elliott Funeral Home
(b) Address 2008 Aliceanna St

19 (a) APR 12 1948 (Date rec'd by registrar) Huntington Williams Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/10 1948 at 11 15 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 4-4 1948 to 4-10 1948 and that I last saw her alive on 4-10 1948.

Immediate cause of death BRONCHO-PNEUMONIA — Duration

Due to CONFINEMENT TO BED

Due to Fracture of neck of left femur

Other Conditions arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 8/6
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 4/2/48 at 7 00 AM
(c) Where did injury occur? BALTIMORE, MD. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? HOME (Specify type of place) While at work? No
(e) Means of injury Fall on arising from bed

23. Signature Paul G. Herold
Address Md. Gen Hosp Date signed 4/10/48
~~Dr P H C~~ Referred by Thomas J. Mullen MD

VS 150

X

G62164

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G62164

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 10.2
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1437 E Eager St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Amos Owens
3 (b) If veteran, name war
3 (c) Social Security Account No. 215-09-7897

4. Sex M. | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 6-20-87

8. AGE: Years 60 | Months ? | Days 15 | If less than one day: hr. ..... min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation
11. Industry or business ?

FATHER 12. Name ?
13. Birthplace ?

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof April 12 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location .....

18 (a) Funeral director Robert L. Conner
(b) Address 1216 a Cardine St.

19 APR 12 1948 (Date received by registrar) Huntington Williamson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1948 at 8:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 7 1948 to April 8 1948, and that I last saw h[illegible] alive on April 8 1948.

Immediate cause of death: R cerebral Hemorrhage — Duration: 18 Hours
Due to: Hypertensive & arteriosclerotic — Duration: ?
Due to: cardiovascular disease
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas E. Van Metre Jr. M.D.
Address Johns Hopkins Hosp Baltimore Md Date signed 4/18/48

VS 50

662165
AB-54555

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 13 B

Registered No. 662165

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 58yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Stemmers Run (If outside city or town limits, write RURAL and give town)
(d) Street No. 310 Stillwater Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rudolph Kuessner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Mary (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept- 29- 1882

8. AGE: Years	Months	Days	If less than one day
66	6	11	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Rudolph or Adolph Kuessner
13. Birthplace Germany

MOTHER
14. Maiden Name Mary ?
15. Birthplace Germany

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR 13 48 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location 4300 BELAIR RD.

18 (a) Funeral director THE DIPPEL BROTHERS
(b) Address 1800 E LOMBARD ST.

19 (a) APR 12 1948 (Registrar's signature) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10- 1948, at 3.30PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-9- 1948 to 4-10- 1948, and that I last saw him alive on 4-10- 1948.

Immediate cause of death: Bilateral pulmonary Thrombosis — Duration: 9 hrs

Due to

Due to

Other Conditions Both Diseases — Duration: ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury.

23. Signature William H. Kuhns J. M. D.
Address Balt City Hosp Date signed 11 Apr. 48

VS 150

G62166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G62166 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland 15, 4

(b) Street address

(c) Hospital or institution: Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3½ MOS.

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1902 N. Fulton Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Lotta W. Collett

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	W

6 (b) Name of husband or wife WM F. COLLETT 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT 27, 1871

8. AGE: Years	Months	Days	If less than one day
76	6	13	hr. min.

9. Birthplace BALTO., MD (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER

12. Name JAMES J. BEAVERS

13. Birthplace Va

MOTHER

14. Maiden Name REBECCA W. DAY

15. Birthplace HARFORD CO., MD

16 (a) Informant LOTTA W. COLLETT

(b) Address 1902 N. FULTON AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/12/48 (month) (day) (year)

(c) Cemetery or crematory LAUDON PK.

Location BALTO., MD.

18 (a) Funeral director WM J. TICKNER & SONS

(b) Address BALTO., MD.

19 (c) APR 12 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1948, at 7¹⁵ A.M.

21. I certify that death occurred on the date above stated: that I attended deceased from March 6 1948, to April 10 1948, and that I last saw HER alive on April 9 1948.

Immediate cause of death	Duration
Lobar pneumonia, left lung.	5 weeks
Due to	
Fracture, comminuted, intertrochanteric, left femur.	3½ mos.
Other Conditions Arteriosclerosis, generalized.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above. 4/10/48

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 15/4

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence 12-25-47 at ? M

(c) Where did injury occur? 1902 N. Fulton Ave (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No

(e) Means of injury Slipped & fell to floor

23. Signature Alfred H. Dann

Address Maryland General Hosp. Date signed 4/10/48 M. D.

Thomas J. Mercer, M.D. ✕

VS 150

G62167

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G62167
Registered No.

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2515 Cold Spring Lane
(c) Hospital or institution: 2716
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2515 Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH KLASMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Julia nee Cohen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20, 1903

8. AGE: Years	Months	Days	If less than one day
44	8	22	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business Merchant

FATHER
12. Name Mordecai Klasman
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie Scher
15. Birthplace Russia

16 (a) Informant Mrs. Julia Klasman
(b) Address 2515 Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 13 4 (month) (day) (year)
(c) Cemetery or crematory Anshei Emunah Cem. Co.
Location Washington Blvd.

18 (a) Funeral director Sol. Levinson & Bros.
(b) Address 1124 - 26 N. North Ave.

18 (c) Date received by local registrar APR 13 1948 Signature of local registrar

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1948 at 4:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/8 1948 to 4/11 1948
and that I last saw him alive on 4/11 1948

Immediate cause of death: Acute Coronary infarction — Duration

Due to Coronary Sclerosis

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at A.M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Hornstein M. D.
Address 204 E. Biddle St. Date signed 4/14/48

G62168 ✓ 652168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 109a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: West Baltimore General Hosp
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland St
(c) Hospital or institution 153

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
a State Md b County
c City or town Baltimore (If outside city or town limits, write RURAL and give town)
d Street No. 1733 Ruxton Ave (If rural give location)
e Citizen of foreign country? (Yes or No) If yes, name country ✓

3 (a) FULL NAME David I Margolis
3 (b) If veteran, name war
3 (c) Social Security Account No. 219-01-2976

4. Sex: Male | 5. Color or race: White | 6 a. Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Late Pearl Nee Lowe
6 (c) If alive, give age years

7. Birth date of deceased: mo. day yr. 1884

8. AGE: Years 64 Months Days If less than one day: hr. min.

9. Birthplace: Baltimore Md (Town, county and state)

10. Usual Occupation
11. Industry or business: Calvert Laundry

FATHER 12. Name: Solomon Margolis
FATHER 13. Birthplace: Russia

MOTHER 14. Maiden Name: Jennie Meister
MOTHER 15. Birthplace: Russia

16 (a) Informant: Mr Moses Hyman
16 (b) Address: 3854 Dolfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: April 13, 1948 (month) (day) (year)
17 (c) Cemetery or crematory: Hebrew Rosedale Cemetery
Location: Hamilton Ave

18 (a) Funeral director: Sol Levinson & Bros
18 (b) Address: 1124-1126 W North Ave

19 (a) (Date received by Registrar) APR 12 1948 (b) (Registrar) Lexington Williams MD (Registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 12 1948 5:40 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 3-24 1948 to 4-12 1948, and that I last saw him alive on 4-12 1948

Immediate cause of death: Brain abscess (probable)
Due to: Friedlanders pneumonia
Due to:
Other Conditions: left pulmonary cyst
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: W.W. Birkeman MD
Address: W. Balt Gen Hosp Date signed 4-12-48

X

662169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

662169 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5904 Harford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carr, Lemuel M.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	M.

6 (b) Name of husband or wife Carrie Stifler Carr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1876

8. AGE: Years	Months	Days	If less than one day: hr	min.
72	2	7		

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Asst. Supt. of Train
11. Industry or business Chamber of Commerce

MOTHER / FATHER
12. Name George W. Carr
13. Birthplace
14. Maiden Name Friella
15. Birthplace

16 (a) Informant Mrs Carrie Carr
(b) Address 5904 Harford Road
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 13, 1948 (month) (day) (year)
(c) Cemetery or crematory Pine Grove
Location Rayville, Balto. Co.
18 (a) Funeral director Roland L. Fisher
(b) Address 2112 Dundalk Ave.
18 (c) Date registered APR 19 1948 Washington Williams, Registrar

VS 180

MEDICAL CERTIFICATION 11:30

20. DATE OF DEATH April 9 1948, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 9 1948 to Apr 9 1948, and that I last saw him alive on — 19 —.

Immediate cause of death Coronary occlusion — **Duration**

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Latham M. D.
Address Franklin Sq. Hosp. Date signed Apr 9, 1948
For O.R. Davis, by Howard J. Haslam, M.D.

G62170

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

106a

Registered No. G62170

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 421 Edgewood St.
(c) Hospital or institution: 20-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 421 Edgewood Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Salvatore Anello

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	

6 (b) Name of husband or wife Josephine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/14

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Tavern owner
11. Industry or business

FATHER
12. Name Louis Anello
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Theresa Anello
(b) Address 421 Edgewood Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12-1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem. Location Old Frederick Road

18 (a) Funeral director Joseph Tavare, Inc.
(b) Address 2073 Freemont Ave

19 (a) APR 12 1948 (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9th, 1948 19 at 3:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 26 1948 to April 9 1948, and that I last saw him alive on 4/8/48 19.

Immediate cause of death	Duration
Acute Congestive Heart Failure	short
Due to Acute Bronchitis & Bronchial Asthma	2 wks
Due to	
Other Conditions Arterial Sclerosis	Long

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. B. Underhandler M.D.
Address 1901 Eutaw Place Date signed 4/9/48

Hilda Cabredonae

G62171

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 108

Registered No. G62171

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 821 W. Fairmount Ave.
(c) Hospital or institution: 18-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 821 W. Fairmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Richard H. Jones.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	C	married

6 (b) Name of husband or wife Cassie Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1882

8. AGE: Years	Months	Days	If less than one day hr.	min
66	-	18		

9. Birthplace Calvert County, Md.. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Jones.
13. Birthplace Calvert Co., Md.

MOTHER
14. Maiden Name Frances Allen
15. Birthplace Calvert Co. Md.

16 (a) Informant Wilbur Jones.
(b) Address 821 W. Fairmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 13 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by Registrar) (b) Registrar

Apr 12 1948 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1948, at 7.30 A.M.

21. I certify that death occurred on the date above stated: that I attended deceased from Apr. 7 1948. to Apr. 9 1948.
and that I last saw him alive on Apr. 7. 1948.

Immediate cause of death	Duration
Bi lat. Lobar Pneumonia	3 days
Due to Bronchitis	3 weeks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Mansell Lawrence M. D.
Address 1033 W Lanvale St. Date signed 4/10/48

X

C 662172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47E

Registered No. 662172

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave & Madison St
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 73 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4026 Clifton Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick W. Claybrook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Helena L. Claybrook

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 29, 1885

8. AGE: Years	Months	Days	If less than one day: hr	min.
62	11	13		

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Designer

11. Industry or business

FATHER
12. Name Frederick W. Claybrook
13. Birthplace Northumberland Co. Va.

MOTHER
14. Maiden Name Mary F. Dew
15. Birthplace Virginia

16 (a) Informant Helena L. Claybrook
(b) Address 4026 Clifton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 13/19 48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Baltimore Co. Md.

18 (a) Funeral director Harry F. Tomaczak
(b) Address 4204 Edgewood Ave

19 (Date rec'd by Registrar) APR 12 1948 Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1948, at 7:05 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 29 1948, to April 11 1948, and that I last saw him alive on April 11 1948.

Immediate cause of death Cardio-respiratory failure — Duration

Due to Generalized carcinomatosis

Due to Carcinoma of pleura

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Jacobs, Asst
Address Md Gen Hosp Date signed M 4/11/48 D

VS 150

X

G62173

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G62173

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 305 E CROSS ST
(c) Hospital or institution: 24-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits write RURAL and give town)
(d) Street No. 305 E CROSS ST (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME JOHN D DETERS

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-18-9165

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	DIVORCED

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 12 1896

8. AGE: Years	Months	Days	If less than one day
51	8	29	hr min

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation RATE CLERK.

11. Industry or business W. T. COWAN CO

FATHER
12. Name JOHN H DETERS
13. Birthplace BALTO MD

MOTHER
14. Maiden Name MARIE ANN BUSCH.
15. Birthplace BALTO. MD.

16 (a) Informant MISS ALICE DETERS
(b) Address 305 E CROSS ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-13-48 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location A.A Co

18 (a) Funeral director Bernard E Hartle
(b) Address 1921 E West St

19 (a) APR 12 1948 (Date rec'd by registrar) Curtis M Simmons

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1948, at 6.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-7-48 to 4-10-48
and that I last saw h[illegible] alive on 4-10-48

Immediate cause of death [illegible] Duration 3 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(e) Means of injury

23. Signature [illegible] M D
Address [illegible] Date signed 4-12-48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G62174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

Registered No. G62174

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St. 15-7
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1530 Ellamont St (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas E. H. Oldham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	MARRIED

6 (b) Name of husband or wife MRS. MARGUERITE Oldham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 3, 1888

8. AGE: Years	Months	Days	If less than one day: hr	min
59	8	9		

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation ENGINEER

11. Industry or business NATIONAL BREWERY

FATHER
12. Name Spencer T Oldham
13. Birthplace England

MOTHER
14. Maiden Name Nannie E North
15. Birthplace ENGLAND

16 (a) Informant Mrs. MARGUERITE Oldham
(b) Address 1530 Ellamont St

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 4/15/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director G. Vernon Lemmon
b Address 4611 Pk. Hgts.

19 (a) APR 12 1948 (b) Registrar Huntington Nicholas, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1948, to April 12 1948, and that I last saw him alive on April 12 1948

Immediate cause of death Ruptured peptic ulcer. Generalized peritonitis

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 4/10/48

Major findings of operation: Perforated peptic ulcer

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work)
(Specify)
(e) Means of injury

23. Signature R. W Johnson III

Address Union Memorial Hosp Date signed 4-13-48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6621'75

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124B

Registered No. 6621'75

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp. 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write R.F.D. and give town)
(d) Street No. UNKNOWN no home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Bailey

3 (b) If veteran, name war **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	

6 (b) Name of husband or wife **6 (c) If alive, give age** years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr. min.
70			

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (burial, cremation, or removal) (b) Date thereof

(c) Cemetery or crematory
Location University Medical School APR 9, 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 APR 1948 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1948, at 7 05 PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis.
Fatty degeneration of liver

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (What was he doing at work?)
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 5-3-48

VS 151

X

662176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. 662176

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 Brentwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Dixon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 52 | Months | Days | If less than one day: hr. min.

9. Birthplace (Town, county, and state) Unknown

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month)

(c) Cemetery or crematory

Location University Medical School APR 5, 1948

18 (a) Funeral director Commissioner of Health

(b) Address Huntington Williams, M.D.

19 (Date received by registrar) APR 12 1948

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-28-1948, at 1830 M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congestive heart failure

Due to

Other Conditions

(Include diseases, injuries, and morbid conditions)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? (Specify)

(d) Means of injury

23. Signature M.D.
Medical Examiner

Date signed 3/29/48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 153

Registered No. 621'77

621'77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lion Ave & Madison St
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Washington
(c) City or town Hagerstown (If outside city or town limits, write RURAL and give town)
(d) Street No. 449 Clarendon Ave (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME James B Clingan

3 (b) If veteran, name war

3 (c) Social Security Account No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 24 1884

8. AGE: Years	Months	Days	If less than one day
63	6	17	hr. min.

9. Birthplace Penn (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Matilda J.
15. Birthplace Md.

16 (a) Informant Mrs Eugene Clingan
(b) Address 449 Clarendon Ave Hagerstown Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-14-48 (month) (day) (year)
(c) Cemetery or crematory Rest Haven
Location Hagerstown Md.

18 (a) Funeral director Reid & Young
(b) Address Hagerstown Md.

19 (a) APR 12 1948 (Date rec'd by registrar) (b) Funeral Director's Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1948, at 11:00 P M

21. I certify that death occurred on the date above stated, that I attended deceased from April 11 1948, to April 11 1948, and that I last saw h[illegible] M alive on April 11 1948.

Immediate cause of death Circulatory Failure — Duration

Due to Generalized Eczema & folliculitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury

23. Signature O. Jones Hunt M. D.
Address Md. Date signed 4/14/48

VS 150

621178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 621178

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Penitentiary Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days) One
(e) Length of stay in Baltimore (yrs., mos., or days) 7 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County St. Mary's
(c) City or town Michaelsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A. Owens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1910

8. AGE: Years 37 | Months 10 | Days 29 | If less than one day: hr. min

9. Birthplace Chaptico, St. Mary's, Md. (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Moses C. Owens
13. Birthplace St. Mary's Co.

MOTHER
14. Maiden Name Gertrude Watkins
15. Birthplace St. Mary's Co.

16 (a) Informant Moses C. Owens
(b) Address Michaelsville, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-14-48
(c) Cemetery or crematory St. Joseph
Location Morganza, Md.

18 (a) Funeral director W. S. Matthews Son
(b) Address Leonardtown, Md.

19 APR 12 1948 (Date received by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 19 48 at 4:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary artery disease

Due to

Other Conditions

(Include pregnancy within three months of death)

22. If an external cause was primary or secondary [illegible] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? What was he doing?
(d) Means of injury

23. Signature Per Earl L. Royer, M.D. Medical Examiner M.D.

Date signed 4-10-48

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G62179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G62179 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 1925 N. Longwood St
(b) Street address [redacted]
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1925 N. LONGWOOD ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME DON WOODS MALAMBRE

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. YES

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife LAURA B. (NEE MARSHACK)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT 11, 1868

8. AGE: Years	Months	Days	If less than one day: hr	min
79	5	29		

9. Birthplace BALTO. MD. (Town, county, and state)

10. Usual Occupation
11. Industry or business RED STAR BUTTON CO. (NY)

FATHER 12. Name JAMES M. MALAMBRE
13. Birthplace DAYTON, OHIO

MOTHER 14. Maiden Name EMMA V. WOODS
15. Birthplace BALTO

16 (a) Informant MR. GUY MALAMBRE
(b) Address 923 CHESTNUT HILL AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/13/48 (month) (day) (year)
(c) Cemetery or crematory LORRAINE
Location BALTO CO. MD

18 (a) Funeral director WM. T. TICKNER & SONS
(b) Address BALTO MD

19 (a) APR 14 1948 (Date received by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/10 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/27/48 19 to 4/10/48 19. and that I last saw him alive on 4/9/48 19

Immediate cause of death: Chr Myocarditis — Duration: 3 wks
Due to: Senility
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature [signature] M.D.
Address 1901 Eutaw Place Date signed 4/10/48

VS 150

C62180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered C62180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2612 N. Charles St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 2612 N. Charles St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Susannah M. Creamer

3 (b) If veteran, name war (c) Social Security Account No

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed or divorced Married

6 (b) Name of husband Chas. F. Creamer

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Sept 11th 1880

8. AGE: Years 67 | Months 7 | Days 1 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business None

FATHER 12. Name William Hyde

13. Birthplace India

MOTHER 14. Maiden Name Ella McComas

15. Birthplace Balto. Md.

16 (a) Informant Chas. F. Creamer

(b) Address 2612 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/48 (month) (day) (year)

(c) Cemetery or crematory Green Mount

Location Balto. Md.

18 (a) Funeral director Williams Cook Inc

(b) Address 617 St Paul St.

19 (a) Date rec'd by registrar APR 13 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12th 1948 at 3.40 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from August 1947 to April 9th 1948 and that I last saw h M alive on April 9th 1948.

Immediate cause of death Congestive Heart Failure

Due to /

Due to

Other Conditions /

(Include pregnancy within three months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

about 1 1/2 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature H. T. Pamplin M.D.

Address 627 E. N. Ave Date signed 4/12/48

VS 150

X

G62181

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G62181 Registered No. 164c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address RAYNER AVE & DUKELAND ST.
(c) Hospital or institution: WEST BALTO GENRL Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15-03

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 2537 W. North Ave (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME William J. Harris

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. NO

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	MARRIED

6 (b) Name of husband or wife: DORIS MARIE HARRIS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT 19, 1910

8. AGE: Years	Months	Days	If less than one day: hr.	min.
37	5	21		

9. Birthplace BALTO., MD. (Town, county, and state)
10. Usual Occupation SALESMAN
11. Industry or business SELF.

FATHER
12. Name JOHN W. HARRIS
13. Birthplace CHESTERTOWN, MD

MOTHER
14. Maiden Name MARY FOX
15. Birthplace MD.

16 (a) Informan MRS. DORIS M. HARRIS (WIFE)
(b) Address 2537 W NORTH AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/14/48 (month) (day)
(c) Cemetery or ~~crematory~~ WESTERN
Location BALTO. MD.

18 (a) Funeral director WM J. TICKNER & SONS
(b) Address [illegible] Huntington Indiana, MD

19 (a) APR 12 1948 (b) (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 Aug. 1948, at 8:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH [illegible]

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10 Aug. at 8:55 A.M.
(b) Where did injury occur? 2537 W. North Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home (While at work?) NO
Means of injury [illegible]

23. Signature [illegible] Medical Examiner M.D.
Date signed 11 Aug 48

G62182

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G62182 Registered No. 92c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da
(e) Length of stay in Baltimore (yrs., mos., or days) Native

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 150 4 Calvert Rd, Balt. Md (If rural give location)
(e) Citizen of foreign country? VS (Yes or No) If yes, name country

3 (a) FULL NAME W. John Lloyd Adelsberger

3 (b) If veteran, name war — No
(c) Social Security Account No. YES

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife (SEE REMARKS) (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) Nov. 4, 1901

8. AGE: Years 46 | Months 5 | Days 7 | If less than one day hr. min.

9. Birthplace Balt. Md. (Town, county, and state)

10. Usual Occupation Salesman
11. Industry or business American Sugar Refining Co

FATHER 12. Name John M. Adelsberger
13. Birthplace Balt, Md.

MOTHER 14. Maiden Name Ruth Boswell
15. Birthplace Balt., Md.

16 (a) Informant wife
(b) Address 150 4 Calvarth Rd, Balt. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/49 (month) (day) (year)
(c) Cemetery or crematory LORRAINE
Location BALTO Co., MD.

18 (a) Funeral director WM J. TURNER & SONS
(b) Address BALTO, MD.

19 (a) (Date received by registrar) (b) 1949

Funeral Director

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1949 at 11 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 7 1949 to April 11 1949 and that I last saw him alive on April 11 1949

Immediate cause of death: Cerebral Embolus — Duration

Due to Valvular Heart Disease

Due to Rheumatic Fever

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature M. L. Williams
Address Union Mem Hosp Date signed 4-11-49 (M D)

VS 159

G 6-183

662183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 662183

662183

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial 9-07
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1536 Roundhill Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME L. AGATHA COBURN

3 (b) If veteran, name war —

3 (c) Social Security Account No. NONE

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife BENJAMIN H. COBURN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 22, 1904

8. AGE: Years 43 | Months 5 | Days 18 | If less than one day hr. min.

9. Birthplace HARFORD Co., MD. (Town, county, and state)

10. Usual Occupation H

11. Industry or business

FATHER 12. Name WALTER A. WATTERS

13. Birthplace MD.

MOTHER 14. Maiden Name LILLIE A. SPAMER

15. Birthplace BALTO., MD.

16 (a) Informant MR. BENJAMIN H. COBURN

(b) Address 1536 ROUND HILL RD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/13/48 (month) (day) (year)

(c) Cemetery or crematory ROCKY REST

Location BALTO. Co. MD.

18 (a) Funeral director WM J. TICKNER & SONS

(b) Address BALTO

Date rec'd by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/10/48 19 . at 7:15 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Carcinoma of Breast

with metastases

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John L. Davis M.D.
Medical Examiner

Date signed 4/11/48

NOTE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cause is especially important. Physicians: please write the causes of death clearly and legibly.

G62184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

✓ G62184 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5219 Cuthbert Ave
(c) Hospital or institution: 27-16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 5219 Cuthbert Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian V. Reightler

3 (b) If veteran, name war

3 (c) Social Security Account No

4. Sex Female | 5. Color or race White | 6 (a) ~~Single~~, married, ~~widowed or~~ divorced Married

6 (b) Name of husband Geo. F. Reightler

6 (c) If alive, give age years

7. Birth date of deceased mo., day, April 27 1864

8. AGE: Years 78 | Months 11 | Days 14 | If less than one day hr. min

9. Birthplace Md (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Samuel Cauliflower
13. Birthplace Md.

MOTHER 14. Maiden Name Amanda Eckert
15. Birthplace Md

16 (a) Informant George F. Reightler
(b) Address 5219 Cuthbert Ave

17 (a) Burial, cremation or removal (b) Date thereof 4/14/48 (month) (day) (year)

(c) Cemetery or crematory United Brethren
Location Timonium Md

18 (a) Funeral director William Cook Inc.
(b) Address 1217 E. Fayette St

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. (Registrar)

VS (S)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11th 1948, at 4:30 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-37 to 4-11 1948, and that I last saw her alive on 4-10 1948

Immediate cause of death: Pulmonary Edema — Duration: 1 wk

Due to: Myocardial degeneration — 7 years

Due to: Arteriosclerosis — ??

Other Conditions

(Including pregnancy within three months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theodore H. Eglon M.D.
Address 5611 Loch Raven Blvd Date signed 4-12-48

G62185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G62185

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1712 Guilford Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RFD or name of town)

(d) Street No. 1712 Guilford Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Arthur Lee Guest

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-4660

4 Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Tobiela

6 (c) If alive, give age yrs.

7. Birth date of deceased mo. day yr. Oct 9 1887 If less than one day hrs. min.

8. AGE: Years 60 Months 6 Days 2

9. Birthplace Baltimore City Md (Town, county and state)

10. Usual Occupation Salesman Cabinet

11. Industry or business

MOTHER / FATHER

12. Name Jacob Kendig Guest Md

13. Birthplace Baltimore Co Md

14. Maiden Name Rebecca Comer

15. Birthplace Baltimore Md

16 (a) Informant Mrs Tobiela Guest

(b) Address 1712 Guilford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/48 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Woodlawn Md

18 (a) Funeral director Wilson Cole

(b) Address 1214 Light St

19 Filed 4/13 1948 (Date filed by registrar) Huntington Williams Md (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1948 at 8:45 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 2-11 1948 to 4-11 1948 and that I last saw him alive on 4-11 1948

Immediate cause of death	Duration
Hypertensive Cardio-Vascular Disease	2 yrs
Due to Emphysema	10 yrs
Due to Carcinoma of Rectum	6 mo
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature C. D. Glynn M. D.

Address 11 E Chase St Date signed 4-12-48

VS 150 Rev. 9-48

X

C62186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122a

Registered No. C62186

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 606 E. 31st St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Skorenko
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased mo., day, yr. Sept. 30, 1878
8. AGE: Years 69 Months 6 Days 11 If less than one day hr. min.
9. Birthplace Poland (Town, county and state)
10. Usual Occupation NW.
11. Industry or business

FATHER
12. Name michal Szenko
13. Birthplace Poland

MOTHER
14. Maiden Name Rosa Truszka
15. Birthplace Poland

16 (a) Informant Anna Broka, Rose Test
(b) Address 606 E 31st St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.
18 (a) Funeral director Williams Cook Inc.
(b) Address 1217 N. Paca St
19 APR 13 1948 (Date received by registrar) Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-11-48 19 at 10 P.M
21. I certify that death occurred on the date above stated, that I attended deceased from Mar. 16, 1948 to Apr. 11, 1948. and that I last saw her alive on Apr. 11, 1948.
Immediate cause of death Peritonitis

Duration

Due to Intestinal obstruction

Due to Peritoneal adhesions

Other Conditions

Date of operation (1) 3-24-48 (2) 4-10-48
Major findings of operation: (1) At obstructor serum, mesentery and (2) Intest obst. due to adhesions
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury
23. Signature Frank J. Brady M.D.
Address Md Gen'l Hosp. Date signed 4-11-48

VS (8)

G62187

AB-118609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G62187

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10days
(e) Length of stay in Baltimore (yrs., mos., or days) 15yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 201 E.Lanvale Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Munn

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 29- 1902

8. AGE: Years	Months	Days	If less than one day
45	5	12	hr. min.

9. Birthplace N.J. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Edward Munn
13. Birthplace N.J.

MOTHER
14. Maiden Name Katherine Jillette
15. Birthplace N.J.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ve.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto., Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 APR 13 1948 (Date rec'd by registrar) (by) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11- 1948 A.10P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-1- 1948 to 4-11- 1948, and that I last saw h in alive on 4-11- 1948

Immediate cause of death: Air Embolus — Duration

Due to

Due to

Other Conditions: Pulmonary tuberculosis; artificial pneumothorax (Include pregnancy within 3 months of death)

Date of operation 4-8-48

Major findings of operation: Pleural adhesions

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?) (Specify type of place)
(e) Means of injury

23. Signature Manning M. Lacy, M.D. M. D.
Address Baltimore City Hosp. Date signed 4-12-48

VS 150

X

US-076M

G62188

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. G62188

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State MD
(b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 2214 Worthington Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl

GRACE

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced

20. DATE OF DEATH April 10 1948 8 A.M.

6 (b) Name of husband or wife

6 (c) If alive, give age years

21. I certify that I took charge of the remains described above, held an Inspection and Do thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: 1 hr. 30 min.

IMMEDIATE CAUSE OF DEATH
Prematurity
Atelectasis

Due to

Other Conditions

(Include pregnancy with which death)

9. Birthplace Balto city md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm Grace
13. Birthplace 2214 Worthington Blvd

MOTHER
14. Maiden Name Ryder
15. Birthplace Balto md

16 (a) Informant Father
(b) Address 2214 Worthington Blvd

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in general place in public place? (Specify)
(d) Means of injury

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/48

(c) Cemetery or crematory Mt. Lord Ridge
Location Wash Blvd

18 (a) Funeral director Edward Toulson
(b) Address 230-9 Wash Blvd

23. Signature George G. Merrill M.D.
Medical Examiner.

19 APR 12 1948 (Date received by Registrar) (b) Registrar Huntington Williams, M.D.

Date signed 4/10/48

MS 151

G62189

48-07612

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. G62189

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto City Hosp. 25-3 DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 2214 Washington Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy GRACE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			1 hr 30 min

9. Birthplace Balto city Md (Town, county and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Wm Grace
13. Birthplace 2214 Wash Blvd

MOTHER
14. Maiden Name Reyter
15. Birthplace Md.

16 (a) Informant Father
(b) Address 2214 Wash Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/48

(c) Cemetery or crematory Woodlawn Ridge
Location Wash Blvd

18 (a) Funeral director Edward Foulon
(b) Address 2369 Wash Blvd

19 APR 13 1948 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 1948 at 8 A.M. 30

21. I certify that I took charge of the remains described above, held an Inspection and Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Prematurity
Atelectasis

Due to

Other Conditions

(Include pregnancy within three months of death)

22. If an external cause was primary ☐ or contributory ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George H. Merrill M.D. Medical Examiner

Date signed 4/10/48

VS 151

G62190

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93

G62190 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 19-1
(b) Street address
(c) Hospital or institution: Franklin Square
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 324 Bruce St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Gray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6 3

8. AGE: Years 86 | Months | Days | If less than one day: hr | min

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Agnes Chew
(b) Address 1813 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/48

(c) Cemetery or crematory Mt Auburn
Location Balto Md

18 (a) Funeral director Chas H Harper
(b) Address 510-12 Cameron Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1948, at 6:25 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardio-vascular disease.

Due to

Other Conditions

(Include pregnancy within three months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner
Date signed 4/12/48

VS 151

X

G62191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

Registered No. G62191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: S. Balto. Gen'l. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel Co.
(c) City or town Glenburnie (If outside city or town limits, write RURAL and give town)
(d) Street No. Richie Highway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary L. E. Queen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1916

8. AGE: Years	Months	Days	If less than one day
31			hr. min.

9. Birthplace (City, town, county, and state) Anne Arundel Co.

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Alexander Edwards
13. Birthplace Anne Arundel Co.

MOTHER
14. Maiden Name Rose Parker
15. Birthplace Anne Arundel Co.

16 (a) Informant Elijah Queen
(b) Address Severn, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 14 48 (month, day, year)
(c) Cemetery or crematory Severn. Md
Location

18 (a) Funeral director James A Hayes
(b) Address 142 W Pleasant St Annapolis Md

19 (a) APR 13 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1948, at 9:40 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ✓, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture - dislocation of the first cervical vertebra, herniation of brain tissue

Due to Acute alcoholism

Other Conditions Subarachnoid hemorrhage, laceration of the cerebellum

(Include pregnancy within three months of death)

22. If an external cause was primary ✓ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 11 48 9:00 P. M.
(b) Where did injury occur? Crain Hwy.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Highway While at work? No
(d) Means of injury Pedestrian Struck by automobile

23. Signature Howard J. Mallonee M.D.
Medical Examiner.

Date signed 4-13-48

VS 151

G62192

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

59 B

Registered No. G62192

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 EUTAW PL
(c) Hospital or institution:
15-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1925 N. LONGWOOD ST (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME LAURA B. MALAMBRE

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced WIDOW

6 (b) Name of husband or wife JOHN W. MALAMBRE

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr SEPT 27, 1871

8. AGE: Years 76 | Months 6 | Days 16 | If less than one day hr min

9. Birthplace CECIL CO. MD. (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name THEODORE MARSHALL

13. Birthplace

MOTHER 14. Maiden Name RACHEL A. FULTON

15. Birthplace LANCASTER CO., PA.

16 (a) Informant MR. GUY MALAMBRE

(b) Address 912 CHESTNUT HILL AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/13/48 (month) (day) (year)

(c) Cemetery or crematory LORRAINE

Location BALTO. CO. MD.

18 (a) Funeral director WM. H. TICKNER & SONS

(b) Address BALTO., MD.

19 APR 13 1948 (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/11 1948, at 9:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1938 19 . to 4/11/48 19 .

and that I last saw her alive on 4/10/48 19 .

Immediate cause of death: Pernicious Anemia — Duration: 10 yrs.

Due to

Due to

Other Conditions Chr. Arthritis — slow

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (While at work)

(e) Means of injury

23. Signature J. B. Culbertson M.D.

Address 1901 Eutaw Place, City Date signed 4/12/48

J. B. Culbertson M.D.

C62193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

Registered No. C62193

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 7-5
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. D.O.A
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1527 E. Madison St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence W. Purviance Purviance

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Lydia Purviance

6 (c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): Mar. 10 1895

8. AGE: Years: 53 | Months: 1 | Days: - | If less than one day: hr. min.

9. Birthplace: Baltimore - Md. (Town, county, and state)

10. Usual Occupation: laborer

11. Industry or business

FATHER
12. Name: Thomas Purviance
13. Birthplace: Baltimore - Md.

MOTHER
14. Maiden Name: Mary E. -
15. Birthplace: Baltimore - Md.

16 (a) Informant: Lydia Purviance (wife)
(b) Address: 1527 E. Madison st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Apr-14-48 (month) (day) (year)

(c) Cemetery or crematory: Arbutus Mem Park
Location: Baltimore - Md.

18 (a) Funeral director: J. L. Preston Limberry
(b) Address: 1631 - Druid Hill Ave

APR 13 1948 (Date rec'd by Registrar) Curtis G. Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 April, 1948, at 7:12 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Gunshot wound of Rt. lung.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: 10 April 1948 at 7:15 P.M.
(b) Where did injury occur? 713 N. Carolina St
(c) Did injury occur at home, on farm, industrial place, in public place? Tavern (While at work?) No
(d) Means of injury: Shotgun at Bar

23. Signature: [illegible] M.D. Medical Examiner.
Date signed 11 April 1948

VS 151

C62194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C62194

83c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hopkins Hospital 8-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town, write RURAL and give town)
(d) Street No. 2037 Llewellyn ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Pulley Pulley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/7/1905

8. AGE: Years 42 | Months 5 | Days 6 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name James W. Pulley
13. Birthplace Md

MOTHER
14. Maiden Name Harriett Smith
15. Birthplace Md

16 (a) Informant: Dolores Cooper
(b) Address Chase Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-13-48 (month) (day) (year)
(c) Cemetery or crematory Sharp St Cemetery
Location Chase Maryland

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 APR 13 1948 (Date received by Registrar) Huntington Williams MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 April 1948 at 2 P. M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pulmonary edema, necrosis of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 11 April 48

VS 151

G62195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. G62195

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1720 E. Pratt St
(c) Hospital or institution: 2-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1720 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia Dominick

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced	6 (b) Name of husband or wife	6 (c) If alive, give age
Female	White	Married	Joseph	years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Macionis
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Joseph Dominick
(b) Address 1720 E Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. J. Fialkowski
(b) Address 2007 Eastern Ave

(Date rec'd by registrar) (Registrar) Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1948, at 5:30 p M

21. I certify that death occurred on the date above stated; that I attended deceased from March 12 1947 to April 11 1948, and that I last saw h[illegible] alive on April 11 1948.

Immediate cause of death Primary Carcinoma pancreas Metastasis to liver — Duration 2 yrs

Due to — Duration

Due to — Duration

Other Conditions Bronchopneumonia — Duration 4 days
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John V. Fezekas M. D.
Address 1302 Eastern Date signed 4-13-48

V S 150

G62196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓

Registered No. G62196

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 809 OGDEN ST
(c) Hospital or institution: 26-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city limits, write RURAL and give town)
(d) Street No. 809 OGDEN ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES SCHWARZ

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 212-10-6708

4. Sex M. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced MARRIED.

6 (b) Name of ~~husband or~~ wife JOSEPHINE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-19-1875

8. AGE: Years 72 | Months 3 | Days 24 | If less than one day hr. min.

9. Birthplace BALTO (Town, county, and state)

10. Usual Occupation BAKER.

11. Industry or business KOESTER'S BAKERY

FATHER
12. Name HENRY SCHWARZ
13. Birthplace GERMANY

MOTHER
14. Maiden Name ELIZABETH SCHAD
15. Birthplace GERMANY

16 (a) Informant JOSEPHINE SCHWARZ.
(b) Address 809 OGDEN St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-15-48 (month) (day) (year)
(c) Cemetery or crematory ST MATTHI
Location O'Donnell Ft.

18 (a) Funeral director Geo H. Leimbach.
(b) Address 25 N. Eutaw St
(Date rec'd by registrar) APR 13 1948 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-12 1948 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to 4-12 1948 and that I last saw ~~him~~ her alive on 4-12 1948

Immediate cause of death

Duration

Due to Hypertension 9 mo

Due to Cardio Vascular Disease

Other Conditions Acute Cardiac Dilatation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fred Ruzicka M. D.
Address 800 N Wolfe Date signed 4-12-48

VS 150

Jan 8 M x 4-12-48

C62197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. C62197

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga ST

(c) Hospital or institution: Mercy Hosp. 11-3

(d) Length of stay in hospital or inst. (~~yrs.~~ ~~mos.~~, or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days) 86 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 700 Park Ave (If rural give location)

(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Sally B. Cooke.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr Dec. 18, 1861

8. AGE: Years 86 Months 3 Days 25 If less than one day hr min

9. Birthplace Chambersburg Pa. (Town, county and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name William I Cook

13. Birthplace Chambersburg, Pa.

MOTHER 14. Maiden Name Alice Hopkins

15. Birthplace Balto. Md.

16 (a) Informant Mary Alice Dandy

(b) Address Wyman Park Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/48 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore, Md.

18 (a) Funeral director H. H. Weary and Son

(b) Address 850 Calvert St. Huntington Williams, Mgr

19 (a) APR 13 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12, 1948 at 4:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-30-1948 to 4-12 1948. and that I last saw her alive on 4-12 1948

Immediate cause of death: Cerebrovascular Accident

Due to Hypertensive C V R Disease

Due to Arteriosclerotic C V R Disease

Other Conditions P.O. Colon Resection for Carcinoma

(Include pregnancy within 3 months of death)

Date of operation 4-7-48

Major findings of operation: Carcinoma of Splenic flexure of colon; Diverticulosis of colon; Arteriosclerosis

of autopsy: Autopsy not obtained. Diagnosis made at time of operation and at autopsy

Duration
24 hrs.
??
??

PHYSICIAN

Underline the causes to which death should be charged statistically

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature Joseph Li Puma M.D.

Address Mercy Hosp. Date signed 4-12-48

VS 180

Found:- Foot of Carolina Street

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 662198

662198

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Block East Street
(c) Hospital or institution: City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 1708 Lancaster St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sigurd Svensen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	

6 (b) Name of husband or wife Irene Svensen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1891

8. AGE: Years	Months	Days	If less than one day
57	1		hr min

9. Birthplace Norway. (town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name No Record
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Irene Svensen
(b) Address 1708 Lancaster St

17 (a) Buried (Burial, cremation, removal) (b) Date thereof Apr. 14/48

(c) Cemetery or crematory Mt Carmel
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 1930 Eastern Ave

19 APR 13 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1948 at 6 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following
(a) Date of injury Found 4-7-48 at 5:16 P. M. 3/2
(b) Where did injury occur? Found: Foot of Caroline St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public (Harbor) (Where? Work?) No
(d) Means of injury Accidental Drowned

23. Signature Carl R. Kyle M.D. (Medical Examiner.)
Date signed 4/8/48

VS 151

G62199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G62199

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 INVERNESS AV.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 F
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 INVERNESS AV. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WALENTY SKOWRONSKI

3 (b) If veteran, name war —

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife JOSEPHINE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
71			hr min.

9. Birthplace POLAND (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business

FATHER
12. Name NO RECORD
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant JOSEPHINE SKOWRONSKI
(b) Address 1400 INVERNESS AV.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APRIL 14/48 (month) (day) (year)
(c) Cemetery or crematory Holy ROSARY
Location BALTIMORE

18 (a) Funeral director Fred W Ozozenski
(b) Address 1930 EASTERN AV.

19 (a) APR 12 1948 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 11 1948, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1948 to April 11 1948, and that I last saw him alive on March 27 1948.

Immediate cause of death Arteriosclerotic Cardiovascular disease — Duration

Due to

Due to

Other Conditions Gangrene both lower extremities — 3 mos.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Arthur Rossberg M.D.

Address 2411 Washington Blvd. Date signed 4/12/48

VS 150

062200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 062200

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1819 W. Mulberry St.
(c) Hospital or institution: 20-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia Holland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col.	Widow

6 (b) Name of husband or wife Louis Holland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1873

8. AGE: Years	Months	Days	If less than one day
74	5	1	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Charles Turner
13. Birthplace Md

MOTHER
14. Maiden Name Susan Joyce
15. Birthplace Carroll Co Md

16 (a) Informant Louis Holland
(b) Address 521 Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 14 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) APR 13 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1948 at 2.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 26 1948 to April 11 1948.
and that I last saw her alive on April 10 1948.

Immediate cause of death Pneumonia Lobar
Hypostatic, Cardio-renal
Renal disease

Duration
Short yrs.

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. McDonald M.D.
Address 844 S Carey Date signed 4/18/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 13

Registered No. 662201

662201

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 916 N. Carrollton Ave.

(c) Hospital or institution: 16-1

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 916 N. Carrollton Ave.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Ernestine Chandler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 7, 1936

8. AGE: Years 11 | Months 7 | Days 5 | If less than one day: hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER 12. Name Ernest Hardings

13. Birthplace St. Marys Co. Md.

MOTHER 14. Maiden Name Justina Chandler

15. Birthplace Balto. Md

16 (a) Informant Justina Chandler

(b) Address 916 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 15, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn.

Location

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N. Schroeder St.

19 (a) APR 13 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-12- 1948, at 6 50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-8- 1947 to 4-12- 1947 and that I last saw h alive on 4-12-1948

Immediate cause of death: Pulmonary T.B. — Duration: 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature George C. Page M. D.

Address 1816 N. Mobert St. Date signed 4-13-48

VS 150

662202

662202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 662202

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 436 E. Lorraine
(c) Hospital or institution: 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 436 E. Lorraine (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Milton Joshua Little

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	widowed

6 (b) Name of husband or wife Anna Downey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9. 1875.

8. AGE: Years	Months	Days	If less than one day
73	3	4	hr. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Peter Little
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Eliza Shaffer
15. Birthplace Carroll Co. Md.

16 (a) Informant Mrs. Arthur Higgins
(b) Address 504 E. 23rd St. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 16. 1948 (month) (day) (year)
(c) Cemetery or crematory Leisure
Location Westminster, Md.

18 (a) Funeral director H. Bankard, Son
(b) Address Westminster, Md.

19 (a) APR 13 1948 (Date rec'd by registrar) (b) Burial Permit Issued

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/13 1948 at 24 M

22. I certify that death occurred on the date above stated; that I attended deceased from 1/4 1948 to 4/13 1948 and that I last saw him alive on 4/11 1948.

Immediate cause of death

	Duration
Pulmonary Embolus	2 days
Due to Diabetes Mellitus	7 years
Due to Amputation of Leg	3 years
Other Conditions due to Diabetes Gangrene	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Chas. W. Cole
Address 214 S. W. Balto St. Date signed 4/13/48

VS 150

G62203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. G62203

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1323 Eutaw 25-5

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1323 Eutaw (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Geo. Wm. Laucht

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Wh.	

6 (b) Name of husband or wife Emma Laucht

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 5 1872

8. AGE: Years	Months	Days	If less than one day
76	2	7	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Policeman

11. Industry or business

FATHER 12. Name Christian Lauchs

13. Birthplace Germany

MOTHER 14. Maiden Name Van Vonlindenberg

15. Birthplace Germany

16 (a) Informant Son Geo. Lauchs

(b) Address 1323 Eutaw St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/48 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Baltimore

18 (a) Funeral director Leonard J. Fuchs

(b) Address 5305 Harford Rd.

19 (a) APR 13 1948 (Date rec'd by registrar) (b) Evelyn Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 · 12 1948, at 1 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1946 to March 26 1948, and that I last saw h[illegible] alive on 3-26 1948.

Immediate cause of death Myocardial failure — Duration about years

Due to

Due to

Other Conditions Mitral Stenosis, Arteriosclerosis — 3

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. H. Summers M. D.

Address 1045 Dolphin Date signed 4/12/48

H. H. Summers

G62204

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G62204

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3724 PENNINGTON AVE
(c) Hospital or institution: 25.5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
a State MD b County
c City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
d Street No. 3724 PENNINGTON AVE (If rural give location)
e Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH COYNE

3 (b) If veteran, name war: —
3 (c) Social Security Account No. —

4. Sex: FEM
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOW
6 (b) Name of husband or wife: WM. J COYNE
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): NOV-13-1885
8. AGE: Years: 62 Months: 4 Days: 29 If less than one day: hr. min.
9. Birthplace: BALTIMORE MD (Town, county, and state)
10. Usual Occupation: STORE KEEPER
11. Industry or business: FOR SELF

FATHER
12. Name: GROSSKOPF
13. Birthplace:

MOTHER
14. Maiden Name:
15. Birthplace:

16 a Informant: MRS GEORGE FORD
b Address: 3724 PENNINGTON AVE

17 a BURIAL (Burial, cremation, or removal) b Date thereof: 4-15-45 (month) (day) (year)
c Cemetery or crematory: HOLY CROSS
Location: A. A. Co.

18 a Funeral director: Bernard C Hance
b Address: 121 E Huntington Indiana, Inc

19 a APR 13 1945 Registrar
Registrar

VS 152

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 11 1945 at 10:40 P M

21. I certify that death occurred on the date above stated, that I attended deceased from APRIL 10 1945 to APRIL 11 1945, and that I last saw her alive on APRIL 11 1945

Immediate cause of death: Acute Coronary Occlusion, due to Arterio-Sclerotic Cardio-Vascular Disease — Duration: 1 day

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
a Accident, suicide, or homicide
b Date of occurrence at M
c Where did injury occur? (City, town, or county) (State)
d Did injury occur at home, on farm, industrial place, in public place? (While at work?)
e Means of injury

23. Signature: Paul Lubin
Address: 320 Park Ave Date signed: 4/14/45
Paul Lubin

62205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. 62205

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2 USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 918 St. Barnabas Court (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Holland alias King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gracie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 1, 1878

8. AGE: Years: 50 | Months: 1 | Days: 8 | If less than one day: hr min

9. Birthplace S. C. (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name
13. Birthplace S. C.

MOTHER
14. Maiden Name
15. Birthplace S. C.

16 (a) Informant Gracie Holland
(b) Address 915 Barnabas Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apl 14 1948

(c) Cemetery or crematory Baltimore National
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Avenue

19 (a) APR 12 1948 (Date received by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 48 at 12 50 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Bullet wound of heart & lung

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4/9/48 at 12 20 P.M.
(b) Where did injury occur? 949 Pennsylvania Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Pool Room (Public) While at work? No
(d) Means of injury Firearms

23. Signature Howard J. Thaden M.D.
Medical Examiner
Date signed 4/9/48

VS 151

G62206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G62206

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1700 Ashburton St

(c) Hospital or institution: 167

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1700 Ashburton St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph W. PENCE

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Myrtle M Pence

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) July 25 1898

8. AGE: Years 49 Months 8 Days 17 If less than one day hr. min.

9. Birthplace Mt Jackson Va (Town, county, and State)

10. Usual Occupation Laundry Foreman

11. Industry or business U. S. Govt Hosp

FATHER 12. Name Joseph PENCE

13. Birthplace Va

MOTHER 14. Maiden Name ROSE JEWELL

15. Birthplace Va

16 (a) Informant Myrtle M. Pence

(b) Address 1700 ashburton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 15-1948 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Balto Md

Location

18 (a) Funeral director Jeff C & B.M. Walter

(b) Address Patterson Park Ave & Huntington Ave, Balto Md

19 (a) APR 13 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1948, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 1948 to April 11 1948 and that I last saw him alive on April 11 1948.

Immediate cause of death Cardiac failure — Duration

Due to Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify) (Specify)

(e) Means of injury

23. Signature Alfred Scagnetti, M.D.

Address 1729 W Lombard Date signed 4/12/48.

VS 150

062207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

Registered No. 062207

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2105 Sinclair Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2105 Sinclair Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard R. Bradley Sr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-09-0207

4. Sex: Male

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marie M. Bradley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 20-1896

8. AGE: Years 51 | Months 3 | Days 22 | If less than one day: hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Standard Oil Co.

FATHER
12. Name Wilson E. Bradley
13. Birthplace Md.

MOTHER
14. Maiden Name Julia C. Traft
15. Birthplace Balto.

16 (a) Informant Mrs. Marie M. Bradley
(b) Address 2105 Sinclair Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/48 (month) (day) (year)

(c) Cemetery or crematory Holy Rademeer
Location Baltimore

18 (a) Funeral director Philip Hesing Sons
(b) Address 2924 Orleans St

19 (a) APR 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1948 at 7:57 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 2 1947 to April 11 1948 and that I last saw he/she alive on April 11 1948.

	Duration
Immediate cause of death: Toxic absorption	1 Day
Due to: Bronchogenic Carcinoma	1 year
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation April 7, 1947

Major findings of operation: Carcinoma of the lung with invasion of the chest wall

Autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Michael J. Daniel M. D.
Address 1 N. Amelia Ave Date signed 4/13/48

V S 190

G62208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. G62208

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University 4-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 N. Paca Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EFFIE VNUCAC

3 (b) If veteran, name war

3 (c) Social Security Account No

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Matt Vnucac

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 2, 1904

8. AGE: Years 43 | Months 2 | Days 10 | If less than one day: hr min

(42)

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Frederick Buchner

13. Birthplace Germany

MOTHER 14. Maiden Name Katherine --

15. Birthplace Baltimore

16 (a) Informant Matt Vnucac

(b) Address 115 N. Paca St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 13/48

(c) Cemetery or crematory Maryland Mem Pk Baltimore

Location

18 (a) Funeral director Philip Henrich Sons

(b) Address 2024 Orleans St

19 (a) Date received by Registrar APR 13 1948 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12/48 19 at 7p M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH asphyxiation due to illuminating gas

Due to

Other Conditions

(Include pregnancy within three months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 4/12/48 6:00p M.

(b) Where did injury occur? 115 N. Paca Street

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Turned on gas

23. Signature John P. Davis M.D.
Medical Examiner.

Date signed 4/13/48

VS 181

X

G62209

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G62209

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr 4mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 836 N EUTAW ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Michael [redacted] V KELLY
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	W

6 (b) Name of husband or wife MARGARET Kelly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) SEPT 6 1867

8. AGE: Years	Months	Days	If less than one day: hr	min
90	7	5		

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace IRELAND

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace UNKNOWN

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St. Baltimore

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7 17 48 (month, day, year)
(c) Cemetery or crematory CATHEDRAL
Location ED MONSON AVE

18 (a) Funeral director CHAS. F. EVANS & SON INC
(b) Address 118 W. MT. ROYAL AVE

19 (a) APR 13 1948 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1948, at 12:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr-1- 1948 to Apr-10 1948, and that I last saw h[illegible] alive on Apr-10- 1948.

Immediate cause of death	Duration
Edema Lungs	10 day.
Due to Chronic myocarditis	3 yrs.
Due to	
Other Conditions Arteriosclerosis	5-

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)
(e) Means of injury

23. Signature E G Hall M. D.
Address 1631 E North Date signed 4/12-48

X

G62210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

77E

Registered No. G62210

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 9-9
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Mos
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 E. Federal St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Preston R. Hockensmith

3 (b) If veteran, name war None

3 (c) Social Security Account No. 181-03-7188

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed or divorced Married

6 (b) Name of husband or wife Ruth C. Garner

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) April 1888

8. AGE: Years 60 (59) | Months - | Days | If less than one day: hr | min

9. Birthplace Chambersburg Penna (Town, county and state)

10. Usual Occupation Machinist

11. Industry or business Maryland Dry dock.

FATHER
12. Name Harper Hockensmith
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant: Preston R. Hockensmith
(b) Address 570 N. Patterson Pk

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/48
(c) Cemetery or crematory Post Haven
Location Hagerstown Md

18 (a) Funeral director George F. Ruth Inc
(b) Address 1735 Harford ave Belle Md

19 APR 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1948, at 9:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute gastritis

Due to alcoholism

Other Conditions

(Include pregnancy within three months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place or public place? (White or Colored)
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner
Date signed 4-13-48

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G62211

G62211

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6105 Fair Oak Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore,
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1430 Federal Street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Robert C. Scott

3 (b) If veteran, name war None

3 (c) Social Security Account No. 212-05- 3838

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rose I. Wendler

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) September 8, 1896

8. AGE: Years 51 | Months 7 | Days 4 | If less than one day ###### min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Meter Reader

11. Industry or business Gas & Electric Co.

FATHER
12. Name Robert Scott
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth
15. Birthplace Maryland

16 (a) Informant Mrs. Rose I Scott --(Wife)
(b) Address 1430 E. Federal Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/48

(c) Cemetery or crematory Morlands Yard
Location Taylor Ave Balto Co

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) APR 12 1948 (b) Huntingtown Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12, 1948, at 11 A. M.

21. I certify that I took charge of the remains described above, held an Inspection Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (While at work)
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.

Date signed 4-12-48

VS 181

062212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 062212

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 DRURY LANE
(c) Hospital or institution: 28-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 DRURY LANE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNE S. JOHN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband-or-wife HERMAN A
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 11, 1881

8. AGE: Years	Months	Days	If less than one day
66	7	1	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name LORENZO SNOCKNEY
13. Birthplace MD.

MOTHER
14. Maiden Name MARY HEAPS
15. Birthplace MD.

16 (a) Informant MR HERMAN A JOHN
(b) Address 506 DRURY LANE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APRIL 14 '48 (month) (day) (year)
(c) Cemetery or crematory WOODLAWN
Location WOODLAWN, MD

18 (a) Funeral director Harry H Wright
(b) Address 401 Edmondson Ave

19 APR 13 1948 (Date rec'd by registrar) (Registrar) Huntington Hill, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 12 1948, at 7:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946, to April 12 1948, and that I last saw her alive on April 12 1948.

Immediate cause of death	Duration
Broncho-pneumonia - right	4 days
Due to Chronic pulmonary disease about 4 years probably Bronchiectasis	
Due to	
Other Conditions arteriosclerotic heart disease (Include pregnancy within 3 months of death)	1 year

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work
(e) Means of injury LEO J. BAUER
23. Signature Leo J. Bauer M. D.
Address 1 Mallow Village Date signed 4/14/48

VS 150

107

662213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218

662213 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT ST.
(c) Hospital or institution: MERCY HOSP. 4-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 160 N. GAY ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANDREW HOPE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr AUG. 24, 1886

8. AGE: Years	Months	Days	If less than one day hr.	min.
61 6 2	7	17		

9. Birthplace BOSTON, MASS. (Town, county, and state)
10. Usual Occupation UNEMPLOYED
11. Industry or business

FATHER
12. Name VINCENT HOPE
13 Birthplace BOSTON, MASS.

MOTHER
14. Maiden Name ANNA JOHNSON
15 Birthplace BOSTON, MASS

16 (a) Informant ADM SLIP
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APRIL 14 '48 (month) (day) (year)
(c) Cemetery or crematory ST JOHNS
Location ELLICOTT CITY

18 (a) Funeral director Harry H Witzke
(b) Address 4101 Edmondson Ave

19 (a) (Date received by Local Registrar) APR 13 1948 Huntington Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/10 1948 at 8 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/28 1948 to 4/10 1948, and that I last saw h[illegible] alive on 4/10 1948.

Immediate cause of death CARDIO - RESP. FAILURE - CHRONIC NEPHRITIS - UREMIA — Duration

Due to ACIDOSIS

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Elden H. Pitt, M.D.
Address Mercy Hosp Date signed 4/10/48

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 87E

Registered No. 66214

66214

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 418-E-Lorraine
(c) Hospital or institution: at Lic home 123
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltcity
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 418 E Lorraine
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Austin Dinning

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife: None
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec-17-1930

8. AGE: Years	Months	Days	If less than one day
17	3	25	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name Ernest L. Dinning Jr.
13. Birthplace Balto Co. Md.

MOTHER
14. Maiden Name Grace Binford
15. Birthplace Balto Co. Md.

16 (a) Informant M. E. L. Dinning Jr. Father
(b) Address Boyton-Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Stewart Hogan & Co.
(b) Address 108 W North Ave.

19 (a) APR 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr-12th 1948, at 84 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940 to April 1948. and that I last saw h living on 12 April 1948.

Immediate cause of death: Hyperpyrexia — Duration 24hrs
Due to: Spastic paraplegia
Due to: Birth Injury — 17 yrs
Other Conditions: Epilepsy
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Bayless M.D.
Address 1600 W Lelans Ave Date signed 13 April 48

VS 150

G62215

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 92B

Registered No. G62215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2510 Bartlett Lane
(c) Hospital or institution: 27-1 ✓

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2510 Bartlett Lane
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine M. Monaghan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 1897

8. AGE: Years: 51 | Months: - | Days: 10 | If less than one day: hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Cl O Telephone
11. Industry or business Retired

FATHER
12. Name Angelo J Monaghan
13. Birthplace Lucca Co Italy

MOTHER
14. Maiden Name Mary E. L. Fredericks
15. Birthplace Adelaide

16 (a) Informant Mrs Thos Griffin
(b) Address 2510 Bartlett Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-14-48 (month) (day) (year)
(c) Cemetery or crematory St Marys Seminary
Location Baltimore Md

18 (a) Funeral director John J Langrehr
(b) Address 1210 Light St.

19 APR 13 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11th 1948, at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1939 to Apr. 11 1948 and that I last saw her alive on Apr. 11 1948.

Immediate cause of death: Chronic Myocarditis
Due to Auricular Fibrillation
Due to Chronic Cardiovascular Rheumatic Fever Disease.
Other Conditions Contributory

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration
Not Known
Not Known

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature William A. Linton M. D.
Address 924 N. Paul St Date signed 4-13-48

VS 150

X

G62216

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G62216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Mercy Hospital 9-3
(d) Length of stay in hospital or inst. yrs., mos., or days 2 days
(e) Length of stay in Baltimore yrs. mos. or days Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 3620 Yolando Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Chester M. Kourley

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-01-2209

4. Sex Male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Lola N. Kourley

6 (c) If alive, give age [illegible] years

7. Birth date of deceased mo., day, yr. Jan 2, 1886

8. AGE: Years 62 | Months 3 | Days 10 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Traffic Manager

11. Industry or business Kramer Brothers

FATHER
12. Name James Kourley
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Weaver
15. Birthplace Baltimore, Md

16 (a) Informant Mrs. Lola N. Courley
(b) Address 3620 Yolando Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/48

(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TIGNER & SONS
(b) Address Balto., Md.

19 (a) APR 13 1948 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1948, at 2:[illegible] M

21. I certify that death occurred on the date above stated, that I attended deceased from April 10 1948, to April 12 1948, and that I last saw h[illegible] alive on April 12 1948.

Immediate cause of death: Heart Failure — Duration: 5 days

Due to: Arteriosclerotic heart disease — Duration: yrs.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place or public place? (What at work?)
(e) Means of injury

23 Signature D. Otis Montgomery M.D.
Address Mercy Hospital Date signed 9-12-48

G62217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1161a

Registered No. G62217

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1507 S Lemmon St
(c) Hospital or institution: 19-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 S. Lemmon St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carl Johnson Jr.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-12-48

8. AGE: Years | Months | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Carl Johnson
13. Birthplace Brookville Md

MOTHER
14. Maiden Name Beatrice Johnson
15. Birthplace Virginia

16 (a) Informant Mrs. Leah Johnson
(b) Address 1507 S. Lemmon St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Local Johns Hopkins Medical Schoo APR 13, 1948
18 (a) Funeral director Commissioner of Health
(b) Address
19 (Date received by registrar) APR 13 1948 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1948 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 13 1948 to April 13 1948, and that I last saw h[illegible] alive on April 13 1948

Immediate cause of death: Pulmonary Atelectasis — Duration

Due to

Due to Congenital Atelectasis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gilbert L. Banfield M.D.
Address 72 E. Delta Ave Date signed 4/13/48

VS 150

62218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 62218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address Calvert St.
(c) Hospital or institution Mercy Hospital 20-N
(d) Length of stay in hospital or institution (yrs., mos., or days) 20 A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md
(b) City or town Baltimore, Md.
(If outside city limits, give township or R.F.D. and post office)
(c) Street No. 2720 Loretta ave
(d) Country (If not in U.S.A.)
(e) Length of residence in city or town (yrs., mos., or days) (If less than one day, hrs. or min.) Yes or No?
If yes, name country

3 (a) FULL NAME ALFRED ROCKWELL

3 (b) If veteran, name war
World War I

3 (c) Social Security document No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If widow, give age

7. Birth date of deceased (mo., day, yr.) Oct 19 1887

8. AGE: Years 60 | Months 61 | Days 5' 28 | If less than one day, hr. or min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles N. Rockwell
13. Birthplace Maryland

MOTHER
14. Maiden Name Kate Barnhart
15. Birthplace Maryland

16 (a) Informant Mrs. Charles Rockwell
(b) Address 2720 Loretta ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/48

(c) Cemetery or crematory U. S. National
Location Frederick Rd.

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St.

19 (a) APR 13 1948 (Date received by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12/48 (b) 8:00 P.M.

I certify that I last saw the deceased alive on [illegible], and that I viewed the remains of the deceased on [illegible]. Inspector

Autopsy (Yes or No)?

To the best of my knowledge and belief, death occurred from the cause and at the time stated above.

21. IMMEDIATE CAUSE OF DEATH. Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

22. If an external cause or was primary [illegible] cause of death, fill in the following

(a) Date of injury (b) at M.

(b) Where did injury occur?

(c) Did injury occur at home, [illegible] or public place?

(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner

Date signed 4/13/48

VS 151

62219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 164 C

Registered No. 62219

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert St.
(c) Hospital or institution: Mercy Hospital 12-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 311 E. Lanvale Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WADE EATON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8, 1911

8. AGE: Years 37 Months 0 Days 4 If less than one day hr min

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Walter Eaton

13. Birthplace Maryland

MOTHER 14. Maiden Name Mary J. Lay

15. Birthplace Maryland

16 (a) Informant Mrs. M. J. Jackson

(b) Address Box 150 Route 10 Sparrows Point Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/16/48

(c) Cemetery or crematory Mt. Olivet

Location Frederick ave

18 (a) Funeral director Will Cook Inc.

(b) Address 1217 St Paul St.

19 (a) APR 13 1948 (Date rec'd by registrar) (b) Huntington Williamsport, Md

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12/48 19 4:30p M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide X, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

(a) Gun Shot Wound - Head

Due to

(b) Mental Depression Partial Paralysis

Other Conditions

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following

(a) Date of injury 4/12/48 at 4:00p M.

(b) Where did injury occur? 311 E Lanvale

(c) Did injury occur at home, in farm, industrial place, in public place? Home

(d) Means of injury Shot Self .38 Revolver

23. Signature John R. Devine M.D. Medical Examiner

Date signed 4/13/48

X

G62229 Mbg -1 X G62229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 192 B

Registered No. 44103

The PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 3 wks.

2. USUAL RESIDENCE OF DECEASED:
(a) State S.C. (b) County
(c) City or town Greenville, S.C. (If outside city or town limits, write RURAL and give town)
(d) Street No. 400 Randle St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Freddie Bolonkin
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. 11-4-26
8. AGE: Years 21 | Months 5 | Days 9 | If less than one day hr. min.
9. Birthplace (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Joseph Bolonkin
13. Birthplace Russia

MOTHER
14. Maiden Name ~~Joseph~~ Anna Baltzman
15. Birthplace Russia

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/48 (month) (day) (year)
(c) Cemetery or crematory Beth Israel
Location Greenville, S. C.

18 (a) Funeral director John O. Mitchell
(b) Address 1900 Eutaw St.

19 (a) APR 13 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-13 1948, at 7 35 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 3-21 1948 to 4-13 1948, and that I last saw him alive on 4-13 1948.

Immediate cause of death cardiac failure

Due to Rheumatic heart disease, mitral stenosis and subacute bacterial endocarditis.

Other Conditions

(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Meacham M. D.
Address Johns Hopkins Hosp. Date signed 4/13/48

VS 150

X

C62221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136a

Registered No. C62221

C62221

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2613 W. Fayette Strat
(c) Hospital or institution: 10-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2613 W. Fayette Strat (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Benjamin Warfield

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 218-01-9357

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary J. Warfield

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) January 22, 1880

8. AGE: Years 68 | Months 2 | Days 21 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Engineer Plumber

11. Industry or business Riggs Distilling Co

FATHER
12. Name James B. Warfield
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Matthews
15. Birthplace Ohio

16 (a) Informant Mary Jeanette Warfield
(b) Address 2613 W. Fayette Strat

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-16-48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director George F. Schmidt
(b) Address 2101 Frederick Ave.

19 (a) APR 13 1948 (Filed by registrar) (b) Huntington Woods, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1948, at 11:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from December 1947 to Apr. 12 1948.
and that I last saw h[illegible] alive on April 12 1948.

Immediate cause of death: HEART FAILURE — Duration: 4 Months
Due to Auricullar Fibrillation — About 3 M
Due to —
Other Conditions Urethral Stricture — ?
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melvin N. Borden M. D.
Address 2030 W. Fayette St. Date signed 4/13/48

95a

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G62222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G62222

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Ave
(c) Hospital or institution: 20-C
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 years
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3160 Wilkens Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME E. C. Edith Kaufman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 10-1877

8. AGE: Years	Months	Days	If less than one day
70	6	29	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name William Kaufmann
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Leydecker
15. Birthplace Balto. Md.

16 (a) Informant Elmer C. Smith
(b) Address 2 E. Lexington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 14-1948 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director George C. Schwab
(b) Address 2201 Frederick Ave

19 (a) APR 13 1948 (Date rec'd by registrar) (b) Evangeline Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12th 1948, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1948 to April 12 1948
and that I last saw h[illegible] alive on April 11 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 days
Due to Arteriosclerosis — 2
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [illegible] M. D.
Address [illegible] Date signed April 14

VS 150

62223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 62223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Hartford Rd
(c) Hospital or institution: 24-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. 654 Harvey St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Martha E. Potts

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Thomas L. Potts.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1883

8. AGE: Years 64 | Months 5 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Charles H. Winkler
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Folger
15. Birthplace Maryland

16 (a) Informant Edward L. Booth
(b) Address 705 Scott Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-16-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director George L. Schnabel
(b) Address 2101 Frederick Ave.

19 (a) APR 10 1948 (Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12th 1948 at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947 to April 12 1948.
and that I last saw h[illegible] alive on April 10 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 wk
Due to Hypertension	4 years
Due to	
Other Conditions Chronic Myocarditis	3 years

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence Not at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature [illegible] Hood M. D.
Address 5106 Harford Rd Date signed 4/12/48

VS 150

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

662224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 662224

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPHS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 HRS
(e) Length of stay in Baltimore (yrs., mos., or days) SAME

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town RIVERSIDE (If outside city or town limits, write RURAL and give town)
(d) Street No. 205 SUNBURY ROAD. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME BABY GIRL JACOBS

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4/12/48

8. AGE: Years	Months	Days	If less than one day
			18 hrs min.

9. Birthplace BALTIMORE - MD (City or county) (State)
HARFORD COUNTY
10. Usual Occupation
11. Industry or business

FATHER
12. Name JOHN S JACOBS
13. Birthplace WASH. D.C.

MOTHER
14. Maiden Name CAROLYN WEBSTER
15. Birthplace HARFORD CO. MD

16 (a) Informant JOHN S JACOBS
(b) Address 205 Sunbury Rd Riverside Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 14 48 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Whitaford, Harford Co Md

18 (a) Funeral director J. Boland
(b) Address Huntingtown Williamsport, Md

19 (a) APR 13 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12 1948, at 11.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/12 1948, to 4/12 1948, and that I last saw HER alive on 4/12 1948.

Immediate cause of death PREMATURE BIRTH. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry J. Houseka, M.D.
Address Ft. Jos. Hosp. Date signed 4/12/48

V S 190

62225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 62225

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Md. University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mo.

(e) Length of stay in Baltimore (yrs., mos., or days) 1 Mo

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Harford

(c) City or town Havre de Grace.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 656 Otsego St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country —

3 (a) FULL NAME David Bevan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife Amy C

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr 4/2/55

8. AGE: Years	Months	Days	If less than one day
63	-	11	hr min

9. Birthplace South Wales
(Town, county and state)

10. Usual Occupation Supervisor Trains A.P.G.

11. Industry or business

FATHER — 12. Name John Bevan

13. Birthplace S. Wales

MOTHER — 14. Maiden Name Owens

15. Birthplace S. Wales

16 (a) Informant Wife - Mrs. Amy C

(b) Address Havre de Grace Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/16/48 (month) (day) (year)

(c) Cemetery or crematory Angel Hill

Location Havre de Grace, Md.

18 (a) Funeral director H. Madison Mitchell

(b) Address Havre de Grace, Md.

19 (a) APR 14 1948 (Date received by registrar) (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-13-48 19 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-13 1948 to 4-13 1948, and that I last saw him alive on 4-13 1948.

Immediate cause of death	Duration
(a) Subarachnoid hemorrhage	
Due to (b) middle cerebral artery	
Due to	
Other Conditions Generalized A-S - Heart Failure	

(include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. B. Smith M. D.

Address Med. Hospital Date signed 4-13-48

83a

G62226 B-62226 G62226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1510 W Lafayette Ave
(c) Hospital or institution: 11-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 W Lafayette Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Jemima Short

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15-1865

8. AGE: Years	Months	Days	If less than one day
82	8	27	hr. min.

9. Birthplace New Castle Co Delaware
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business Home

FATHER 12. Name	James Nall Short
FATHER 13. Birthplace	Delaware
MOTHER 14. Maiden Name	Martha Ellen Humphreys
MOTHER 15. Birthplace	Smyrna Del.

16 (a) Informant Mrs Emma J Short
(b) Address 1510 W Lafayette Ave
17 (a) Removal (b) Date thereof April 16-1948
(Burial, cremation, or removal) (month, day, year)
(c) Cemetery or crematory Glenwood Cemetery
Location Smyrna Del
18 (a) Funeral director Rodgers Bros
(b) Address 2224 N Charles St
19 APR 14 1948 Huntington Williams Mill
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1948 at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to April 12 1948 and that I last saw her alive on April 7 1948.

Immediate cause of death: Arteriosclerosis — Duration Gradual
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature W H Jacky M. D.
Address 1403 Park Ave Date signed 4-13-48

VS 150

2227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

66 2227

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 27 N. Carey St

(c) Hospital or institution Bad Lancaster Home | E.V

(d) Length of stay in hospital or inst. yrs., mos. or days

(e) Length of stay in Baltimore yrs. mos. or days

3 a FULL NAME Lucy A Parks

3 b If veteran, name war — Social Security Account No

4. Sex

5. Color or race

6 a Single, married, widowed, or divorced

Female White Widowed

6 b If single, give age years

6 c Name of husband Jefferson Parks

7 Birth date of deceased mo. day yr. Feb 2nd 1872

8 AGE Years Months Days If less than one day, hrs. or min.

76 2 10

9 Birthplace Hooperville Md (Town, county and state or foreign country)

10 Usual Occupation Housewife

11 Industry or business At home

FATHER

12 Name Charles Parks

13 Birthplace Md

MOTHER

14 Maiden Name Mary White

15 Birthplace Md

16 a Informant Hattie Simmons Brooklyn

b Address 202 Hillsdale Rd. Md.

17 a Burial, cremation or removal

b Date thereof 4-15-48 month day year

c Cemetery or crematory Hooperville

Location Md

18 a Funeral director William Cook Inc.

b Address 2[illegible] W. Mulberry St.

19 APR 14 1948 Registered by registrar Huntington Williamsville

vs. by

2. USUAL RESIDENCE OF DECEASED:

a State Md b County

c City or town Balto (If outside city or town limits, write RURAL and give town)

d Street No. 27 N Carey St (If rural, give location)

e Citizen of foreign country? (Yes or No) If yes, name country

MEDICAL CERTIFICATION

20 DATE OF DEATH April 12 1948 at 7:45 A.M.

21 I certify that death occurred on the date above stated, that I attended the deceased from Feb 20 1948 to April 12 1948, and that I last saw [illegible] on Feb 12 1948

Immediate cause of death: Uremia — Duration: 3 months

Due to: Nephritis

Due to:

Other conditions

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following:

a Accident, suicide, or homicide

b Date of occurrence at M

c Where did injury occur? (City or town) (County) (State)

d Did injury occur about home, on farm, industrial place, in public place? (While at work)

e Means of injury

23. Signature [illegible] M. D.

Address 27 N Carey St Date signed April 13 1948

He is housewife

PHYSICIAN

Underline the cause to which death should be charged statistically

662228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. 662228

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1312 N. Stricker St.

(c) Hospital or institution

(d) Length of stay in hospital or instit. yrs. mos. or days

(e) Length of stay in Baltimore yrs. mos. or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write R.F.D. and give township)

(d) Street No. 1312 N. Stricker St. (If rural, give location)

(e) Citizen of foreign country Yes or No?

If yes, name country

3. (a) FULL NAME Sarah Elizabeth Herbert

(b) If veteran, name war

(c) Social Security Account No

4. Sex Female

5. Color or race Colored

6. (a) Single, married, widowed or divorced Widow

(b) Name of husband or wife William Mason

(c) If alive, give age years

7. Birth date of deceased mo., day, yr. Sept. 12, 1874

8. AGE: Years 75 Months Days Hours If less than one day, mins.

9. Birthplace St. Mary's Co. Md. (City, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name William Herbert

13. Birthplace St. Mary's Co. Md.

MOTHER

14. Maiden Name Catherine ? ? ?

15. Birthplace St. Mary Co. Md.

16. (a) Informant Miss Catherine C. Herbert

(b) Address 60 Tyson N.W. Wash. D.C.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-14-1948 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore, Maryland

18. (a) Funeral director Geo. Leonard St. Ballard

(b) Address 1601 Druid Hill Ave.

19. (a) Date received by registrar APR 14 1948 (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH (month) Apr. (day) 10, (year) 1948 at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended decedent from Apr. 7, 1948 to Apr. 10, 1948.

and that I last saw h/ alive on Apr. 9, 1948.

Immediate cause of death

Due to Cerebral Embolism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town, County, State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which) While at work?

(e) Means of injury

23. Signature

Address Date signed M D

VS 150

G62229

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G62229

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West. Balto. Hosp.
(c) Hospital or institution 783

(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give township)
(d) Street No. 1921 Forest Pk. Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F Marsh

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex: M.
5. Color or race: W.
6. (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Lillie Marie
6 (c) If alive, give age years

7. Birth date of deceased: Nov. 26, 1888

8. AGE: Years 59 Months 4 Days 19 If less than one day: hr. min.

9. Birthplace: Baltimore, Md
(Town, county, and state)

10. Usual Occupation: Asst. Superintendent
11. Industry or business: Welsbach Corp.

FATHER
12. Name: Charles F. Marsh
13. Birthplace: Ohio

MOTHER
14. Maiden Name: Emma J. Kaufmann
15. Birthplace: Pa.

16. (a) Informant: Loring H. Marsh
(b) Address: 2530 Liberty Pkwy. Dundark

17. (a) Burial (Burial, cremation, or removal)
(b) Date thereof: 4 / 16.48 (month, day, year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville, Md.

18. (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul Street

19. (a) APR - 4 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Signature of registrar)

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-13-48; 6:00 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 4-11-48 to 4-15-48, and that I last saw h[illegible] on 4-13-48

Immediate cause of death: Coronary Thrombosis

Due to: Coronary sclerosis

Due to:

Other Conditions:

Duration

Date of operation:

Major findings of operation:

of autopsy: Pleurisy adhesions

22. If death [illegible] following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: W W Bordeman M.D.
Address: W. Balto. Dun Hwy
Date signed: 4-13-48

PHYSICIAN
Underline the cause to which death should be charged statistically.

662230

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

662230 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: (a) Baltimore City, Maryland — Levindale Home
(b) Street address — Belvedere & Greenspring Ave
(c) Hospital or institution: 15-13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2642 Oswego Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Harry Gibson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1889

8. AGE: Years 59 | Months 3 | Days 12 | If less than one day hr. min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Joseph Gubinsky
13. Birthplace Russia

MOTHER
14. Maiden Name Ethel Price
15. Birthplace Russia

16 (a) Informant Jennie Gibson
(b) Address 2642 Oswego Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 14, 1948 (month) (day) (year)
(c) Cemetery or crematory Bhai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) APR 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1948, at 4:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1948 to April 13 1948, and that I last saw h[illegible] alive on April 12 1948.

Immediate cause of death: Coronary occlusion — Duration
Due to: Chronic heart failure
Due to: Coronary sclerosis
Other Conditions: Diabetes mellitus
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Jerome J. Blumberg M.D.
Address Levindale Home Date signed 4/13/48

VS 150

94a

662231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 662231

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baeto General 8-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1705 Darley Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ARTHUR N. VALENTINE

3 (b) If veteran, name war

3 (c) Social Security Account No. 220071674

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mildred N. Valentine

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) November 28 1903

8. AGE: Years 95 | Months 4 | Days 13 | If less than one day hr. 12 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Tool & Die Inspector

11. Industry or business Western Electric Co

FATHER
12. Name Henry Valentine
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Emma Burgermeister
15. Birthplace Germany

16 (a) Informant Mrs. Mildred N. Valentine
(b) Address 1705 Darley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 14 48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Rose and Milton Ave

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 6009 Harford Road

APR 14 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/10/48 19 . at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: X
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner
Date signed 4/11/48

VS 151

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

62232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

62232 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 948 Ashland Court
(c) Hospital or institution: 16-W
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 948 Ashland Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M. Tolley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Wm. Tolley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1880

8. AGE: Years	Months	Days	If less than one day: hr.	min
67	7	11	12	

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Adolph Wess
13. Birthplace Germany

MOTHER
14. Maiden Name Mary A. Holzlein
15. Birthplace Germany

16 (a) Informant Mrs. A. Sonder
(b) Address 129 S. Loudon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 15, 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Rita Wiedefeld

18 (a) Funeral director 900 East Biddle St
(b) Address

APR 14 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

vs 15

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-12 1948, at 7 00 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/4 1948, to 4/6 1948, and that I last saw h[illegible] alive on 4/6 1948.

Immediate cause of death	Duration
Acute Coronary insufficiency	
Due to Arteriosclerosis Chronic myocarditis	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature A. L. Hornstein M.D.
Address 704 E. Biddle St Date signed 4/14/48

X

G62233

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 192 B

Registered No. G62233

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 608 Hyson St
(c) Hospital or institution: 24-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Hyson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie E. Milder

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife ~~August 16, 1883~~ John D. Milder
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) August 16, 1883

8. AGE: Years	Months	Days	If less than one day
65	7	27	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Michael Cuddy
13. Birthplace MD

MOTHER
14. Maiden Name Catherine Richardson
15. Birthplace Richmond, Va.

16 (a) Informant John D. Milder - Husband
(b) Address 608 Hyson St, Balto 3, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date buried Apr. 16, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Baltimore

18 (a) Funeral director Foos Church St Balto Md
(b) Address

19 APR 14 1948 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July, Apr. 13, 1948, at 2:09 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 29 1948 to Apr 13 1948 and that I last saw him alive on Apr 13 1948

Immediate cause of death: Mitral Regurgitation — Duration 2 wks
Due to acute Edema of lungs. — 3 hrs
Due to —
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature T. C. Campbell M.D.
Address 164 Hanover St Date signed 4/13/48

VS 150

062234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 062234

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 923 N. CALVERT
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANIC HASS (FRANK HASS)

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-4408

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 26 1891

8. AGE: Years 56 | Months 11 | Days 7 | If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business Lord Baltimore Hotel

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. Nelson Burick
(b) Address Lord Baltimore Hotel.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Apr 14.48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Wm McKeever Sons
(b) Address North & Pennsylvania Ave

19 APR 14 1948 (Date rec'd by registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/3/48 19 5:15 P.M

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Sears M.D.
Medical Examiner.
Date signed 4/4/48

X

G62235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. G62235

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1-1
(c) Hospital or institution: Baltimore city Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 812 S. Decker Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Theresa Doris Carter

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: BERNARD V. CARTER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1920

8. AGE: Years 27 | Months 10 | Days 18 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph C. Merryman
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Theresa C. Connor
15. Birthplace Balto., Md.

16 (a) Informant Mrs. John Carter
(b) Address 1508 Clifton ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/48 (month) (day) (year)
(c) Cemetery or crematory St. John's Cem.
Location Long Green, Md.

18 (a) Funeral director WM. J. TICH & SONS
(b) Address Balto., Md.

19 (a) APR 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1948, at 3 10 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to illuminating gas
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-10-48 at 7 M.
(b) Where did injury occur? 812 S Decker Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home (While at work?) no
(d) Means of injury: 4 burners on Gas Stove on but unlit

23. Signature [signature] M.D. Medical Examiner.
Date signed 4-12-48

G62236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G62236

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1304 Etting Street
(c) Hospital or institution: 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1304 Etting St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lee B. Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Fannie B. Brown
6 (c) If alive, give age 46 years

7. Birth date of deceased mo., day, yr. March 15, 1890

8. AGE: Years	Months	Days	If less than one day
49 47	-	27	hr. min

9. Birthplace South Hampton Co., Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Ben Brown
13. Birthplace South Hampton Co., Virginia

MOTHER
14. Maiden Name Fannie Gordon
15. Birthplace South Hampton Co., Virginia

16 (a) Informant Fannie Brown
(b) Address 1304 Etting St., Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 15, 19[illegible] (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Brooklyn, Md.

18 (a) Funeral director Joseph L. Russ
(b) Address 1200 McCulloh St., Baltimore, Md

19 (a) APR 14 1948 (Date rec'd by Registrar) [signature] (Registrar)

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11th, 1948, at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-4-47 1947 to 4-6- 1948 and that I last saw him alive on 4-6- 1948.

Immediate cause of death Hypertensive Type V Heart Disease

Duration

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Evans S. Gilkes
Address 601 N. Calhoun St. Date signed 4/13/48

EVANS S. GILKES X

C62237

BC-4P-08006

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 30F

C62237
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution:
St. Agnes Hospital 19-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 Ramsay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Donnelly

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13th 1948

8. AGE: Years | Months | Days | If less than one day: 6 hr. 30 min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation none
11. Industry or business

FATHER
12. Name Thomas Donnelly
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Dorothy Talbott
15. Birthplace Balto, Maryland

16 (a) Informant Mr Thomas Donnelly
(b) Address 1809 Ramsay St

17 (a) Burial (b) Date thereof 4/14/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location 3801 Frederick Ave

18 (a) Funeral director John J. Sorgan & Son
(b) Address 701-03 Hollins St

19 (a) 4 1948 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/13 1948 at 4:25 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/13 1948 to 4/13 1948.
and that I last saw h/m alive on 4/13 1948.

Immediate cause of death	Duration
Asphyxia	
Prematurity	
Due to Placenta Abruptio	
Due to	
Other Conditions Congenital Syphilis	

(Including pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L Shamin M.D.
Address St Agnes Hospital Baltimore Md
Date signed 4-14-48

1612

C62238

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 195E

C62238
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Hereford (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Everett Floyd Reed, Jr.

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 217-24-8989

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12 1929

8. AGE: Years: 18 | Months: 5 | Days: 1 | If less than one day: hr min

9. Birthplace: Balto. city (Town, county, and state)

10. Usual Occupation: Rigger

11. Industry or business: Patapsco Scrap

FATHER
12. Name: Everett Floyd Reed Sr.
13. Birthplace: Ohio

MOTHER
14. Maiden Name: Ellen Dare
15. Birthplace: Balto Co.

16 (a) Informant: Everett F. Reed Sr.
(b) Address: Hereford Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 15-48 (month, day, year)
(c) Cemetery or crematory: St. Thomas
Location: Balto Co.

18 (a) Funeral director: J. F. Cline & Sons
(b) Address: Reisterstown Md.

19 (a) APR 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1948, at 12:25 P.M.

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypostatic Pneumonia
Pulmonary edema; Renal infarction, left.
Hematoma, retro peritonial
generalized peritonitis

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 25/6
(a) Date of injury 4-9-48 at 1930 a. M.
(b) Where did injury occur? Patapsco Scrap Co.
(c) Did injury occur at home, on farm, industrial place, in public place? industrial plant While at work? yes
(d) Means of injury: fell on floor down to lower gain of boat, striking head

23. Signature: Everett Floyd Reed M.D.
Date signed 4-14-48

VS 151

G62239

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 48a

G62239 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1534 W. Lanvale St.
(c) Hospital or institution: 16-V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore yrs., mos., or days Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1534 Lanvale St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Gladys Watkins
3 (b) If veteran, name war
3 (c) Social Security Account No

4. Sex: Female
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Howard Watkins
6 (c) If alive, give age years
7. Birth date of deceased mo., day, yr. 8-1-1922
8. AGE: Years 25 Months 5 Days 10. If less than one day hr. min.
9. Birthplace South Carolina (Town, county and state)
10. Usual Occupation Domestic
11. Industry or business Own home

FATHER
12. Name Thomas Sudaven
13. Birthplace S. C.

MOTHER
14. Maiden Name Luna Vance
15. Birthplace S. C.

16. (a) Informant Howard Watkins
(b) Address 1534 W. Lanvale St.

17. (a) Burial (b) Date thereof 4/15/48
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. Nat
Location Md
18. (a) Funeral director Geo. U. Kelson
(b) Address 1303 Pennsylvania Ave
19. APR 14 1948 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-11-1948, at 6 P M
21. I certify that death occurred on the date above stated, that I attended deceased from 3-20-1948 to 4-11-1948, and that I last saw her alive on 4-9-1948

Immediate cause of death: Carcinoma of Cervix — Duration: Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 mos. of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work) (Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders MD
Address 1029 N. Stricker St. Date signed 4-14-48 M D

VS 150

X

G62240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G62240

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1823 Kavanaugh St
(c) Hospital or institution N-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) P

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name)
(d) Street No. 1823 Kavanaugh St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Morrison

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	M

6 (b) Name of husband or wife Samuel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/2/1863

8. AGE: Years	Months	Days	If less than one day
73	-	10	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Louis Ruffin
13. Birthplace Va

MOTHER
14. Maiden Name Caroline ?
15. Birthplace Va

16 (a) Informant Birdie Dorsey
(b) Address 1613 W. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/37 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. W. Nelson
(b) Address 1303 Presstman St

19 (a) APR 14 1937 (Date rec'd by Registrar) (b) Burial Permit Issued, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1937 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/9/37 19 to 4/12/37 and that I last saw h alive on 4/10/37

Immediate cause of death Myocarditis

Due to Arteriosclerosis

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature Edward Gordon
Address 1823 Kavanaugh St Date signed 4/14/37

VS 150

G62241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G62241

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 16-1
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name)
(d) Street No. 923 E. Madison St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Casterlow

3 (b) If veteran, name war none

3 (c) Social Security Account No. none

4. Sex male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr 10-01-03

8. AGE: Years 44 | Months 6 | Days 11 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name James Casterlow

13. Birthplace Va

MOTHER 14. Maiden Name Rose Anderson

15. Birthplace Md

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) b Date thereof 4/16/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Lebanon
Location Long Green, Md.

18 (a) Funeral director William J. Eichelman

(b) Address 1701 McCulloh St.

19 (a) Date received by registrar 4/16/48 (b) Signature of Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1948, at 12 00 M

21. I certify that death occurred on the date above stated, that I attended deceased from 3/22 1948 to 4/12 1948 and that I last saw h alive on 4/12 1948

Immediate cause of death UREMIA — Duration 1 year

Due to ? Chronic Pyelonephritis — Duration ?

Due to ? Chronic glomerulonephritis — Duration ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Contracted kidneys

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Thomas E. Van Metre Jr M. D.

Address Johns Hopkins Hosp Date signed 4/12

vs 153

X

C62242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C62242

171C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 207
(c) Hospital or institution: West Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 3511 W. Franklin St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Peter John Dunitscher

3 (b) If veteran, name war None

3 (c) Social Security Account No. 217-01-1409

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lillian M. Dunitscher

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1878

8. AGE: Years 69 | Months 9 | Days 15 | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Baker

11. Industry or business Haugwald Bakery

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Lillian M. Dunitscher
(b) Address 3511 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-48

(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director Geo. L. Edelmann
(b) Address 2101 Frederick Ave

APR Huntington Indiana, Ind.
(Date received by Registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1948, at 1:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said (Autopsy, Inspection or Inquiry) Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture pelvis; Multiple fractures of ribs; Fracture ~~of~~ of right ankle

Other Conditions

(Include pregnancy within three months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-13-48 at 10 20? P.M.
(b) Where did injury occur? Edmondson and Long Woodlawn
(c) Did injury occur at home, on farm, industrial place, in public place? Public (Specify) no
(d) Means of injury? Struck by auto

23. Signature [illegible] M.D. Medical Examiner.
Date signed 4-14-48

G62243

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH . 12 B

G62243 ✓ Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 823 S MILTON AV.
(c) Hospital or institution: 1-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 823 S. MILTON AV (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** MAGDALINA BULACH (BULASZYK)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: JOSEPH BULACH

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr 1. 18[illegible]

8. **AGE:** Years: 64 | Months | Days | If less than one day: hr min

9. Birthplace POLAND (Town, county, and state)

10. Usual Occupation HOUSE WORK

11. Industry or business AT HOME

FATHER
12. Name WITKOWICZ
13. Birthplace POLAND ?

MOTHER
14. Maiden Name
15. Birthplace POLAND

16 (a) Informant JOSEPH BULACH
(b) Address 619 S PATTERSON PK. AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APRIL 16 48 (month) (day) (year)
(c) Cemetery or crematory ST. STANISLAUS
Location BALTIMORE

18 (a) Funeral director Chas. W. Oszczanski
(b) Address 1780 Eastern Ave

19 APR 14 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. **DATE OF DEATH** APRIL 13 1948, at 39. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 19 48 to Apr. 13 1948, and that I last saw her alive on Apr. 13 1948

Immediate cause of death: Uremia — Duration: 3 days

Due to: Bilateral Pulmonary Tuberculosis — 5 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. **Signature** Ernest Levi M.D.

Address 1601 N. Broadway Date signed 4/14/48 M D

VS 150

C62247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 E

C62247 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: 1-4
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 937 N. Chapel St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis WOODRUM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar-4-1895

8. AGE: Years 53 | Months 1 | Days 9 | If less than one day: hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name John Woodrum
13. Birthplace Va

MOTHER 14. Maiden Name Alma ?
15. Birthplace Va

16 (a) Informant Mrs. Margaret Woodrum
(b) Address 937 N Chapel St

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 4-15-48 (month) (day) (year)
(c) Cemetery or crematory Burkeville
Location Virginia

18 (a) Funeral director Raymond Sanders
(b) Address 1403 E. Preston St

19 (a) 1948 (b) (Date received by registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1948, at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection and Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓ or accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Syphilitic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner
Date signed 4/13/48

G62245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G62245

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Loreto Ave
(c) Hospital or institution:
COLONIAL NURSING HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town ARBUTUS
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5113 LEEDS AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM A. GANLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of ~~husband or~~ wife BLANCH A. (SOLLERS)
6 (c) If alive, give age 825 years

7. Birth date of deceased (mo., day, yr.) OCT. 29 (1865)

8. AGE: Years	Months	Days	If less than one day
72	5	15/16	hr. min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual Occupation PLUMBER

11. Industry or business RETIRED

FATHER
12. Name PHILIP GANLEY
13. Birthplace VA

MOTHER
14. Maiden Name EMILY SMITH
15. Birthplace MD

16 (a) Informant MRS BLANCH A GANLEY
(b) Address 5113 LEEDS AVE

17 (a) BURIAL (b) Date thereof APRIL 16 '48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON PK
Location 3801 FREDERICK AVE

18 (a) Funeral director Harry A Wagner
(b) Address 4101 Edmondson Ave

19 (a) Date rec'd by reg~~istrar~~ (b) ~~Registrar~~

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 12 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-11 1948 to 4-12 1948, and that I last saw ~~him~~ her alive on 4-12 1948.

Immediate cause of death
Acute Pulmonary edema
Hypertensive C.V. Heart disease
Due to Arteriosclerosis
Senile Psychosis
Due to

Duration
3 hrs
yrs
yrs
6 mos

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William L. Fearing M. D.
Address 3025 Belay Road Date signed 4-13-48

William L. Fearing X

G62246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

Registered No. G62246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Broadway & Fairmount

(c) Hospital or institution: Church Home & Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days) 6.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Pr. George

(c) City or town [redacted] Aquasco

(If outside city or town limits, write RURAL and give town)

(d) Street No. [redacted]

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME George Boys

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W	married.

6 (b) Name of husband or wife Emma-Lou Boys

6 (c) If alive, give age 44 years

7. Birth date Sept 2nd 1880

8. AGE: Years	Months	Days	If less than one day
67	7	2	hr min

9. Birthplace England

(Town, county, and state)

10. Usual Occupation Clergyman

11. Industry or business Episcopalian Church

FATHER

12. Name Henry I. Boys

13. Birthplace England.

MOTHER

14. Maiden Name Ellen Shackleton

15. Birthplace England.

16 (a) Informant Emma Lou Boys

(b) Address Aquasco, Pr. Geo Co

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/48 (month) (day) (year)

(c) Cemetery or crematory Location Aquasco Md

18 (a) Funeral director Hunt & Ryon

(b) Address Waldorf Md.

19 (a) [illegible] 1948 (b) [illegible] (Date received by registrar)

VS (5)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/14 19 48, at 5.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/13 19 48 to 4/14 19 48 and that I last saw h[illegible] M alive on 4/14 19 48

Immediate cause of death Shock

Due to Post-operative

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4/12/48

Major findings of operation: Carcinoma of Oesophagus.

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible] Huntington Williams M.D.

Address Church Home & Hosp Date signed 4/17/48

G62247

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 52B

G62247 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 15-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life time

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2802 Elsinor Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Goldsmith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Frances Goldsmith

6 (c) If alive, give age years

7. Birth date of deceased: mo., day, yr.

8. AGE: Years 68 | Months 7 | Days 14 | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: Merchant

11. Industry or business

FATHER
12. Name: Benjamin L. Goldsmith
13. Birthplace: Germany

MOTHER
14. Maiden Name: Henrietta Oberbach
15. Birthplace: Pa.

16 (a) Informant: Mrs. Annette Kaufman
(b) Address: 2802 Elsinor Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/48. (month) (day) (year)
(c) Cemetery: Balto. Hebrew
Location: Balto. Md.

18 (a) Funeral director: Harris Levinson Home
(b) Address: 1702 Eutaw Place

APR 14 1948 (Date received by registrar) (b) Huntington Hollins, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 April 1948, at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 17 March 1948 to 12 April 1948; that I saw him alive on 12 April 1948.

Immediate cause of death: Pulmonary embolism (?)

Due to: postoperative uterine

Due to: 2° mixed carcinoma Rt. ovary bladder

Other Conditions (Include pregnancy within 3 months of death)

Date of operation: April 1 1948

Major findings of operation: Cancer of bladder.

of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature: Irving Schenker, M.D.
Address: Sinai Hospital Date signed 13 Ap. 48

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G62248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56B

G62248 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Green Sts

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. yrs., mos., or days

(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County Baltimore

(c) City or town RELAY MD. (If outside city or town, write RURAL and give town)

(d) Street No. 1505 ROLLING RD. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Bessie A Stahl (MELANE)

3 (b) If veteran, name war NO

3 (c) Social Security Account No. NO

4. Sex female (w)

5. Color or race

6. (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Wm. Luther STAHL

6 (c) If alive, give age years

7. Birth date of deceased: mo. day yr. JUL. 7, 1876

8. AGE: Years 71 Months 9 Days 6 If less than one day: hrs. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name H. McLANE GIBBONS

13. Birthplace MD

MOTHER

14. Maiden Name ELIZ. DENT SWAN

15. Birthplace MD

16. (a) Informant MR. Wm. L. STAHL - (HUSBAND)

(b) Address 1505 ROLLING RD. RELAY

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/16/48

(c) Cemetery or crematory LONDON PK.

Location BALTO. MD

18. (a) Funeral director Wm. J. TURNER & SONS

(b) Address BALTO., MD

19. (a) APR 14 1948 (Date rec'd by registrar) Lillian Williamson

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 13 1948 at 6:40 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 3-11-48 to 4-13-48, and that I last saw h[illegible] alive on 4-12-48

Immediate cause of death Coronary occlusion

Duration

Due to hypertension C V disease

Due to

Other Conditions Uterine fibroids Obstruction of colon

Date of operation 3-12-48

Major findings of operation Intramural fibroids. obstr. colon

If autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes (fill in the following):

(a) Accident, suicide or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur while at home, on farm, while at work, in public place?

(e) Manner of injury

(f) Signature G.C. Dewald M.D.

Address Redwood & Green Date signed 4-13-48

662249

BALTIMORE CITY HEALTH DEPARTMENT

662249 Registered No.

CERTIFICATE OF DEATH 163H

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1323 HOMESTEAD ST
(c) Hospital or institution ~~Union Memorial Hospital~~ 45
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md.
(b) City or town Baltimore
(c) Street No. 1323 Homestead St.
(d) Country of foreign residence? Yes or No
If yes, name country

3 (a) FULL NAME Lawrence W. Sanner

3 (b) If veteran, name war NO

3 (c) Social Security Number 219-01-3402

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife MARY E. (NEE RYAN)

6 (c) If widow, give age

7. Birth date of deceased (mo., day, yr.) JUN 21, 1887

8. AGE: Years 60 Months 61 Days 9 2 27

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation SALESMANAGER
11. Industry or business HEATING & REFRIG

FATHER
12. Name JOHN B. DANNER
13. Birthplace BALTO, MD.

MOTHER
14. Maiden Name KATHERINE WEHE
15. Birthplace BALTO, MD

16 (a) Informant MRS MARY E. DANNER
(b) Address 1323 HOMESTEAD ST

17 (a) BURIAL (Burial, cremation, or removal)
(b) Date thereof APR 16, 1948
(c) Cemetery or crematory DEER RIDGE
Location FREDERICK, MD

18 (a) Funeral director WM. T. FICHTNER & SONS
(b) Address BALTO, MD.

19 APR 14 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1948 1:30 P.M.

21. I certify that I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said Coroner, Inspection or myself and Autopsy Inspection or Surgery have that said deceased came to his death on the day stated above, and death in my opinion resulted from natural causes ~~or violence~~ ~~suicide~~ homicide, undetermined and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to Illuminating gas

(Other Conditions)

22. If an external cause was primary ✓ or ~~secondary~~ contributing ~~or~~ cause of death, fill in the following
(a) Date of injury 4-13-48 at ? P.M.
(b) Where did injury occur? 1323 Homestead St.
(c) Did injury occur in home, on farm, in factory, or in public place? Home
(d) Manner of injury Illuminating gas poisoning Suicide
(e) Signature [signature] M.D.
Medical Examiner
Date signed 4-13-48

VS 181

X

G62250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G62250 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1223 Patapsco st
(c) Hospital or institution 1512

(d) Length of stay in hospital or inst. yrs. mos. or days

(e) Length of stay in Baltimore yrs. mos. or days

2. USUAL RESIDENCE OF DECEASED:
a. State Md. b. County
c. City or town Baltimore (If outside city or town limits, write RURAL and give town)
d. Street No. 1223 Patapsco st (If rural, give location)
e. Citizen of (foreign country)? Yes or No?
If yes, name country

3. (a) FULL NAME Marion Burton

3. (b) If veteran, name war — (c) Social Security Account No —

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced W

6. (b) Name of husband or wife Joseph A. Burton
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1, 1879

8. AGE. Years 68 Months 8 Days 11 If less than one day hrs. min.

9. Birthplace Newport (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ? Wallington

13. Birthplace —

MOTHER 14. Maiden Name

15. Birthplace —

16. (a) Informant Charles Barton
(b) Address 1223 Patapsco st

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-1948 (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18. (a) Funeral director Pugsley & Fleming
(b) Address 1710 Light St.

19. (a) (Date received by registrar) APR 14 1948 (Registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1948 at M

21. I certify that I attended the deceased from April 9 1948 and that I last saw her alive on April 9 1948

Immediate cause of death: Pneumonia

Duration 2 Mo.

Due to: arteriosclerosis

Due to:

Other Conditions Senility

(Include pregnancy within three months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Address Date signed M D

X

662251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

662251 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 503 Wilson St
(c) Hospital or institution: 14/2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 Wilson (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Alice Bond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Single (obliterated)

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13 1848

8. AGE: Years 99 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name James Bond
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Emeline Bond
15. Birthplace Baltimore Md

16 (a) Informant Bernice Atanucio
(b) Address 503 Wilson St

17 (a) (Burial, cremation, or removal) (b) Date thereof April 15, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles H. Alexander
(b) Address 1200 McCulloh St., Baltimore, Md.

19 (a) (Date rec'd by reg.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1947 at 10:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 12 1947 to Apr. 12 1947 and that I last saw her alive on April 12 1947.

Immediate cause of death: Cystosclerosis of heart — Duration: 3 wks

Due to: Hypertension — 1 yr

Due to: General debility — 5 yrs

Other Conditions: Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 17 E. Lexington St Date signed

VS 150

93D

662252 Reg. No. 117041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

662252 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave,
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Months
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2404 Homestead ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Augusta Koepka

3 (b) If veteran, name war: No
3 (c) Social Security Account: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12 -1859

8. AGE: Years	Months	Days	If less than one day
88	4	0	hr min.

9. Birthplace MD. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Henry Koepka
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhemina Meise
15. Birthplace Germany

16 (a) Informant Records B lto. City Hospitals
(b) Address 4940 Eastern Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Md.
18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY
19 (a) APR 14 1948 (Date rec'd by registrar) (b) Tuntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 12 - 1948 at 6.25 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 1 - 29 - 1948 to 4 - 12 1948 and that I last saw her alive on 4 - 12 - 1948.

Immediate cause of death: Intestinal Obstruction — Duration
Due to: Strangulated Inguinal Hernia
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. H. Roberson Jr. M. D.
Address Bal City Hosp. Date signed 4/13/48

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

062253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106 B

062253 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4833 Kernwood Avenue

(c) Hospital or institution: 27-11

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4833 Kernwood Avenue (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME EMILY CAMERON LUDLAM

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Samuel Bishop Ludlam

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1852

8. AGE: Years 95 | Months 7 | Days 1 | If less than one day: hr. min.

9. Birthplace: Goshen, N.J. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER 12. Name: Warren Chapman VanGilder

FATHER 13. Birthplace: N.J.

MOTHER 14. Maiden Name: Emily Cameron

MOTHER 15. Birthplace: Penna.

16 (a) Informant: Miss Eliza Bishop Ludlam

(b) Address: Mr. Warren V. Ludlam

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/42 (month) (day) (year)

(c) Cemetery or crematory: Loudon Park Cemetery

Location: Baltimore, Marvland

18 (a) Funeral director: HENRY SANDER & SONS, INC.

(b) Address: NORTH AVE. & BROADWAY

19 (a) [illegible] (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1945. at 3:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 9 1945. to April 12 1945.

and that I last saw her alive on April 12 1945.

Immediate cause of death: Hypostatic Pneumonia — Duration: 72 hrs.

Due to Arteriosclerosis

Due to Coronary Sclerosis — Duration: 2

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide No

(b) Date of occurrence No at M

(c) Where did injury occur? No (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: C. Bartlett Emmart M.D.

Address 7423 Bay Front Ave. Date signed April 12 1945

(Not to be filled in by registrar)

V S 150

X

C62254

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

C62254
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Aberdeen (If outside city or town limits, write RURAL and give town)
(d) Street No. Mt Calvary (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George C Bond
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife: Mary Thomas
6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Mar 16 1887

8. AGE: Years	Months	Days	If less than one day: hr	min
61	1	28		

9. Birthplace Darlington Harford Co Md (Town, county, and state)
10. Usual Occupation Day Laborer
11. Industry or business

FATHER
12. Name George W Bond
13. Birthplace Darlington Md

MOTHER
14. Maiden Name Malinda More
15. Birthplace Churchville Harford Co Md

16 (a) Informant Mrs John B Bond
(b) Address 643 Erie St Havre de Grace Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 17 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Aberdeen Md

18 (a) Funeral director Harry Fanning Sons
(b) Address Aberdeen Md

19 [illegible] 14 1948 (Date rec'd by registrar)
[illegible] Washington Md

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1948 at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 12 1948 to Apr 13 1948, and that I last saw h[illegible] alive on Apr 13 1948.

Immediate cause of death	Duration
Toxemia	10 da.
Due to Gas gangrene R right lower extremity	15 da.
Due to Diabetes mellitus and generalized arteriosclerosis	25 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph F Bamm Jr
Address University Hosp Date signed 4-14-48 (M. D.)

VS 150

G62255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G62255

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3420 St. Ambrose Ave.
(c) Hospital or institution: 27 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3420 St. Ambrose Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Zell Claggett,

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Edward B. Claggett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 15, 1861

8. AGE: Years 86 | Months 8 | Days 27 | If less than one day: hr min

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: at home

FATHER
12. Name: Charles Zell,
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Anna McGinis,
15. Birthplace: Baltomore, Md.

16 (a) Informant: Mr. Grindell,
(b) Address: 3420 St. Ambrose Ave.,

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 4/15/48 (month) (day) (year)

(c) Cemetery or crematory Western Cem Balto. City.
Location

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) APR 14 1948 (Registrar) Luckington Williams, M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12, 1948 at P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/12 1948 to 4/12 1948 and that I last saw her alive on 4/ 1948

Immediate cause of death: Coronary Thrombosis — Duration: 36 hrs

Due to: Cerebral Embolus — Duration: (a)

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A A Weinlaeb M. D.
Address 4603 Park Heights Date signed

Howard J. Weaver, M.D.

G62256

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157E

G62256
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. J. (b) County
(c) City or town Bridgeton (If outside city or town limits, write RURAL and give town.)
(d) Street No. 72 Orford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald Mac Pherson
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex male
5. Color or race White
6 (a) Single, married, widowed, or divorced
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7-20-37
8. AGE: Years 10 Months 6 Days 25 If less than one day: hr. min.
9. Birthplace New Jersey (town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Sherwood Mac Pherson
13. Birthplace N. J.
14. Maiden Name Elizabeth Walker
15. Birthplace N. J.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 Apr 14 1948 Registered by Registrar Evelyn Williams M.A.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1948 at [redacted] M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/9 1948 to 4/17 1948 and that I last saw [him] alive on 4/17 1948

Immediate cause of death Cerebral hemorrhage — Duration 7 hrs.
Due to Acute Leukemia — 6 wks.
Due to
Other Conditions Tetralogy of Fallot. — 10 yrs.
(Describe pregnancy within 3 mos. of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which)
(e) Means of injury

23. Signature John F. Cigler, Jr.
Address The Johns Hopkins Hosp. signed 4-17-48

74a

662257 BLUMENFELD 662257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 510 Hurley Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town (If outside city or town limits, write RURAL and give town) 2016

(d) Street No. 510 Hurley Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Joseph Blumenfeld

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-05-2413

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
Male	White	Married

6 (b) Name of husband or wife Ella Hora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 19th 1885

8. AGE: Years	Months	Days	If less than one day
63	2	25	hr. min.

9. Birthplace Hoboken N. J. (Town, county and state)

10. Usual Occupation Oil Reclamation Operator

11. Industry or business B. & O. R. R.

MOTHER / FATHER

12. Name Isaac Blumenfeld

13. Birthplace Germany

14. Maiden Name Un Known

15. Birthplace -

16 (a) Informant John Firth

(b) Address 1238 Leadenhall Terrace

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 4/17/48 (month) (day) (year)

(c) Cemetery or crematory Western Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

19 (a) APR 15 1948 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1948 at 1.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1944 to April 14 1948 and that I last saw h/ she alive on April 13 1948

Immediate cause of death Myocardial Insufficiency

Due to Hypertensive Cardiovascular

Due to

Other Conditions Chronic Lymphatic Leukemia

(Include pregnancy within 3 months of death)

Date of operation Nov 16 1947

Major findings of operation Synovial Sarcoma, Benign Prostate Hypertrophy

of autopsy:

Duration 3 months

4 years

PHYSICIAN

Underline the cause to which death should be referred statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Earle Pass, M.D.

Address 4051 W. Belvedere Ave Date signed 4-14-48

VS 186

95

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

062258

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 167

Registered No. 062258

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Johns Hopkins Hosp. 7-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1027 N. Dallas St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathaniel Flemming
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If given, give age years

7. Birth date of deceased (mo., day, yr.) May 6th 1923 (If less than one day, hr. min.)

8. AGE: Years 24 | Months 11 | Days 3

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Flemming
13. Birthplace M.D.

MOTHER
14. Maiden Name Susan Whitney
15. Birthplace M.D.

16 (a) Informant Susan Gilbert
(b) Address 1027 N. Dallas St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-1948
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md

18 (a) Funeral director Byron Hamilton Wright
(b) Address 729 Eutaw St

19 APR 15 1948 (Date received by Registrar) Huntington Williams, M.D. Registrar

20. DATE OF DEATH April 9 1948. at 11:30 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Investigation or Inquiry)
by said Autopsy (Inspection or Inquiry) find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hemorrhage from
Stab-wounds of right lung
Right hemothorax.
Acute alcoholism.

Other Conditions

22. If an external cause was primary or secondary (or both) causes of death, fill in the following
(a) Date of injury 4-9-48 at 11 PM.
(b) Where did injury occur? 1104 Orleans St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public
(d) Means of injury Sharp Instrument

21. Signature George G. Merrill M.D. (Medical Examiner)
Date signed 4-10 48

VS 181

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G62259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

G62259

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2309 W. LAFAYETTE

(c) Hospital or institution

(d) Length of stay in hospital or inst. yrs., mos., or days 16 days

(e) Length of stay in Baltimore yrs. mos., or days

2. USUAL RESIDENCE OF DECEASED:

a. State MD b. County

c. City or town BALTO

(If outside city or town limits, write RURAL and give township)

d. Street No. 2309 W. LAFAYETTE Ave.

(If rural give location)

(e) Citizen of foreign country? — Yes or No?

If yes, name country —

3 (a) FULL NAME CLAUDE R FEELEMYER

3 (b) If veteran, name war NO

3 (c) Social Security Account No. YES

4. Sex M

5. Color or race W

6 (a) Single, married, widowed or divorced M

6 (b) Name of husband or wife CARRIE T. FEELEMYER

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. JUNE 5, 1883

8. AGE: Years 64 | Months 10 | Days 4 | If less than one day: hr. min.

9. Birthplace CATONSVILLE, MD (Town, county, and state)

10. Usual Occupation INSURANCE AGENT

11. Industry or business HOME BENEFICIAL INS Co.

FATHER

12. Name GEO. W. FEELEMYER

13. Birthplace CATONSVILLE, MD

MOTHER

14. Maiden Name MARY MACDONALD

15. Birthplace SCOTLAND

16 (a) Informant MRS. CARRIE T. FEELEMYER

16 (b) Address 2309 W. LAFAYETTE AVE

17 (a) Burial (Burial, cremation, or removal)

17 (b) Date thereof 4/15/48 (month) (day) (year)

17 (c) Cemetery or crematory WESTERN

Location BALTO, MD.

18 (a) Funeral director WM. F. TICKNER & SONS

18 (b) Address BALTO, MD

19 (a) APR 15 1948 (Date rec'd by registrar)

Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12/1948

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to 4-12 1948, and that I last saw h[illegible] alive on 4-12 1948.

Immediate cause of death

Due to (a) [illegible] OSIS

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (While at work)

(e) Means of injury

23. Signature Daniel J. Johnson M. D.

Address 2320 [illegible] Date signed 4-15-48

VS 150

C62260 — BALTIMORE CITY HEALTH DEPARTMENT — C62260 Registered No.

CERTIFICATE OF DEATH 1937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1636 BRADDISH AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1636 BRADDISH AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEO. RICHARD SUTER

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
NO	YES	M	W	M

6 (b) Name of husband or wife JOHANNA N. SUTER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 25, 1894

8. AGE: Years	Months	Days	If less than one day hr.	min
53	6	17		

9. Birthplace BALTO, MD. (Town, county, and state)
10. Usual Occupation UNITED RAILWAY
11. Industry or business BALTO. CITY

FATHER
12. Name GEO. SUTER
13. Birthplace BALTO, MD

MOTHER
14. Maiden Name MARY BRESHMILLER
15. Birthplace BALTO, MD

16 (a) Informant MRS. JOHANNA N. SUTER (wife)
(b) Address 1636 BRADDISH AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/15/48 (month) (day) (year)
(c) Cemetery or crematory MT. OLIVET
Location BALTO, MD.

18 (a) Funeral director WM J. TICKNER SONS
(b) Address BALTO, MD.

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12 1948 at 9.15 P M

21. I certify that death occurred on the date above stated, that I attended deceased from April 12 1948 and that I last saw him alive April 12 1948

Immediate cause of death: Coronary Thrombosis — Duration: 1 day
Due to: Hypertensive Cardio-Vascular disease
Due to:

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(e) Means of injury

23. Signature Louis T. Lavy
Address 1844 W. North Ave Date signed 4/14/48

VS 159

G62261 BC-48-07454

A 61966 Hospital Disposal

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G62261

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 27-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 200 Evesham Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Gilbert

3 (b) If veteran, name war —

3 (c) Social Security Account No —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased: mo., day, yr. 4-8-48

8. AGE: Years | Months | Days: 43 | If less than one day: hr. | min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Harry E. Gilbert

13. Birthplace Md.

MOTHER 14. Maiden Name Edyth A. Costa

15. Birthplace Md.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Hebrew Memorial

18 (a) Funeral director

(b) Address

19 (a) APR 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 11 1948 at 9 45 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Apr. 8 1948 to Apr. 11 1948 and that I last saw him alive on Apr. 11 1948

Immediate cause of death Prematurity — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Henry M. Seidel M D

Address Date signed

VS 150

Hospital Disposal

X

C62262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

C62262 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 614 W Franklin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-1
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name)
(d) Street No. 614 W Franklin St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Caplan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	married

6 (b) Name of husband or wife Yetta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-5

8. AGE: Years	Months	Days	If less than one day: hr.	min
63				

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Grocer

11. Industry or business

FATHER 12. Name unknown

FATHER 13. Birthplace Russia

MOTHER 14. Maiden Name unknown

MOTHER 15. Birthplace Russia

16 (a) Informant Yetta Caplan

(b) Address 614 W Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-48 (month) (day) (year)

(c) Cemetery or crematory

Location Pikesville Herring Run

18 (a) Funeral director Jack Lewis Inc

(b) Address 2600 Eutaw Place

19 APR 15 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-14 1948 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1938 to April 1948 and that I last saw him alive on 4/11/48 19

Immediate cause of death	Duration
acute myocardial insufficiency	1/2 hour
Due to Arterio-sclerotic heart disease	10 years
Due to Arterio sclerosis with hypertension	16 years
Other Conditions Trigeminal neuralgia (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Jack Cohen

Address 1804 Eutaw Place Date signed 4/14/48

VS 190

C652263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. C652263

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1706 Jackson St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24-4

(e) Length of stay in Baltimore (yrs., mos., or days) about 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 Jackson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie O. Yeakel

3 (b) If veteran, name war:

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife William Yeakel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 28, 1885

8. AGE: Years	Months	Days	If less than one day
62	5	16 17	hr. min.

9. Birthplace King George Co. Va. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business —

FATHER
12. Name Rhodan A. Douglas
13. Birthplace Westmoreland Co., Va.

MOTHER
14. Maiden Name Sarah Frances Somerson
15. Birthplace King George Co. Va.

16 (a) Informant Mrs. Rosa C. Gibbs (Sister)
(b) Address 2818 Gelbin Heights Rd. Balto. 30 Md

17 (a) Burial (burial, cremation, or removal) (b) Date thereof Apr. 17, 1948 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location A.A. Co., Md.

18 (a) Funeral director A. Howard Evans
(b) Address 4005 Charles St Relay, Md.

19 APR 15 1948 (Date filed by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Wed., April 14, 1948 at 11:00 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 Jan 1948 to April 14 1948 and that I last saw [illegible] alive on April 1948.

Immediate cause of death Carcinoma of Uterus — Duration 3 Mos.

Due to

Due to

Other Conditions Carcinoma of Urinary Bladder (Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: No

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edward F. Mugan M.D.

Address 68 Edgewood Rd. Date signed April 15 1948

VS 150

662264 48-87259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 662264

GM. 118619

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2524 E. Preston ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Myrtle (Dolores)

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4-1-48

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace MD. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Luther Myrtle
13. Birthplace VA.

MOTHER
14. Maiden Name Delores Dulaney
15. Birthplace PA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 4-8-48 9am (month) (day) (year)
(c) Cemetery or crematory Balto. C. H. Crematory
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) APR 15 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 4 - 1948, at 1.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4 - 1 1948 to 4 - 4 1948, and that I last saw h alive on 4 - 4 1948.

Immediate cause of death — Duration

Prematurity — 2 days

Due to

Due to

Other Conditions Bronchopneumonia Aspiration? — 1 day

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Prematurity - Bpneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julian P. Griffin M. D.
Address Balt. City Hosps. Date signed Apr. 8 48

X

G62265

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 307

Registered No. G62265

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5-2
(c) Hospital or institution: Davison Chem. Co. - Curtis Bay
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 637 Ensor St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence HOLMES ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years	Months	Days	If less than one day: hr.	min.
38				

9. Birthplace Richmond Va
(Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name unknown
13. Birthplace " "

MOTHER
14. Maiden Name unknown
15. Birthplace " "

16 (a) Informant Mola Harris
(b) Address 637 Ensor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 16-1948

(c) Cemetery or crematory Mt Calvery Cem
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1848 Broadway ave

19 (a) APR 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1948, at 10:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute congestive cardiac failure
Due to Syphilitic aortitis.
Due to Hypertrophy and dilatation of heart

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (While at work)
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 4/13/48

VS 131

G62266
AB-118815

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 122B

Registered No. G62266

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Williams Crossfile George Webb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10- 1865

8. AGE: Years	Months	Days	If less than one day
82 83	8	-	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Records--Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 15- 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Baltimore Md

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Eutaw ave

19 (a) APR 15 1948 (Date rec'd by registrar) Lexington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10- 1948 at 6.30P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-9- 1948 to 4-10- 1948 and that I last saw h im alive on 4-10- 1948.

Immediate cause of death Volvulus of Sigmoid, acute — Duration 2 days

Due to

Due to

Other Conditions Arteriosclerotic cardiovascular disease; Emaciation (Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. M. Lacy, M. D. M. D.
Address Baltimore City Hosp. Date signed 4-13-48

VS 150

662267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

APR 15 1948 Registered No. 662267

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division st.
(c) Hospital or institution: Provident 16-1
(d) Length of stay in hospital or inst. yrs., mos., or days 28 d.
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 N Fremont (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Malcolm Hankins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	N	Married

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-5-?

8. AGE: Years	Months	Days	If less than one day: hr	min.
50				

9. Birthplace Portsmouth, V. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " "

MOTHER
14. Maiden Name Unknown
15. Birthplace " "

16 (a) Informant Mary Hankins
(b) Address 1200 N. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Elroy D. Wilson
(b) Address 1800 Granby and

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12 1948 at 4 o'clock PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10 1948 to 4/12 1948 and that I last saw h[illegible] alive on 4/12 1948

Immediate cause of death: Myocardial Failure — Duration 2 hrs.
Due to Coronary Thrombosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Peter Grant M.D.
Address 1514 Division Date signed 4/13/48

VS 150

662268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 662268

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dix
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 E. Fayette
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 57 SMT | Months | Days | If less than one day: hr. min.

9. Birthplace unknown
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name unknown
13. Birthplace " "

MOTHER
14. Maiden Name unknown
15. Birthplace " "

16 (a) Informant Martha Dunning
(b) Address 137 N. Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 17-48
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn Md

18 (a) Funeral director Edward O Wilson
(b) Address 1004 Baltimore Ave

19 (a) APR 15 1948 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12 1948 at 4:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C.V. disease

Due to

Other Conditions
(Include pregnancy within three months of death)

22. If an external cause was primary or secondary (Starting ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place?
(d) Means of injury

23. Signature C. J. Fahrenbach M.D.
Medical Examiner.
Date signed 4/16/48

VS 181

G62269

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. G62269

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1619 N Appleton St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 N Appleton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Krome

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years: 67 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: House wife

11. Industry or business

FATHER
12. Name: Samuel Sholom
13. Birthplace: Russia

MOTHER
14. Maiden Name: Unkown
15. Birthplace: Russia

16 (a) Informant: Henry Krome
(b) Address: 1619 Appleton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 15, 1948 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Washington Road
Location: Washington Blvd

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 APR 15 1948 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1948, at 2:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/2 1948 to 4/14 1948, and that I last saw h alive on 4/14 1948.

Immediate cause of death: Acute Myocardial failure — Duration: Unknown

Due to: — Duration: over

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Samuel Morrow

Address: 11 E Chase St 2 Date signed 4/14/48

VS 150

X

652270

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

652270 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 501 N. Streeper St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 501 N. Streeper St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Glock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife H. Henry Glock, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1875

8. AGE: Years	Months	Days	If less than one day
72	4	9	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Federick C. Wattes
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant H. Henry Glock, Jr.
(b) Address 501 N. Streeper St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 16 48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location German Hill Rd.

18 (a) Funeral director Lilly and Butler, Inc.
(b) Address 103 S. Wolfe St.

19 APR 15 1948 Huntington Williams, M.D. (Date received by Registrar) Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH April 13, 1948, at 8:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 1948 to April 13 1948, and that I last saw h[illegible] alive on April 11 1948.

Immediate cause of death — Duration

Due to Coronary occlusion — ?

Due to

Other Conditions Recent influenza

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence At M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Francis L. Janczewski, M.D.
Address 540 N. Linwood Date signed 4/14/48

V S 150

X

062271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/31a

Registered No. 062271

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 862 Vine St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 862 Vine St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Gaylor.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Male

5. Color or race C

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Lillie Gaylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1878

8. AGE: Years 70 | Months 1 | Days - | If less than one day: hr. min.

9. Birthplace Jacksonville, N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alexander Gaylor.
13. Birthplace Jacksonville, N.C.

MOTHER
14. Maiden Name Lilia Files.
15. Birthplace N.C.

16 (a) Informant Mrs. William Gaylor.
(b) Address 2230 N. Howard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 16 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Wallace
(b) Address 3912 N. Schroeder St.

19 (a) APR 15 1948 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1948 at 9P M

21. I certify that death occurred on the date above stated, that I attended deceased from April 4 1948 to April 17 1948 and that I last saw him alive on April 11 1948.

Immediate cause of death
(a) Pneumonia Lobar

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
3
2

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. D. Walker

Address [illegible] Date signed 4/14/48 (M.D.)

VS 150

G62272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G62272

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2702 GREENMOUNT AVE

(c) Hospital or institution

(d) Length of stay in hospital or inst. yrs., mos., or days

(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTIMORE (If outside city or town limits write RURAL and give town)

(d) Street No. 2702 GREENMOUNT AVE (If rural give location)

(e) Citizen of foreign country? Yes or No

If yes, name country

3 (a) FULL NAME SARAH N McGRAW

3 (b) If veteran, name war —

3 (c) Social Security Account No —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEM	WHITE	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7 Birth date of deceased mo., day, yr APRIL 27 1904

8. AGE: Years	Months	Days	If less than one day
43	11	16	15 hr min

9 Birthplace MARYLAND (Town, county and state)

10. Usual Occupation NONE

11. Industry or business —

FATHER

12. Name THOMAS McGRAW.

13 Birthplace WASHINGTON D.C.

MOTHER

14 Maiden Name MARY BARRETT

15 Birthplace PHILA PA

16 (a) Informant MRS DELLA McGRAW

(b) Address 2617 GREENMOUNT AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-16-48 (month, day, year)

(c) Cemetery or crematory ST. JOSEPH'S CEM

Location TEXES MD

18 (a) Funeral director Bernard C Hartle

(b) Address 1331 E West St

19 (a) APR 15 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 17 1948 at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1948 to April 17 1948, and that I last saw h[illegible] alive on April 16 1948

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work)

(e) Means of injury

23. Signature Pauline Wolfe

Address 1331 Mathilde Date signed M D 4-14-48.

X

VS 1-50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G62273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 124a

Registered No. G62273

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2719 Fait Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2719 Fait Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stanley or Stanislaw Gorecki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Frances M Gorecki
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8/1900

8. AGE: Years	Months	Days	If less than one day
48	-	5	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Albert Gorecki
13. Birthplace Poland

MOTHER
14. Maiden Name Agnes Nowak
15. Birthplace Poland

16 (a) Informant Mrs Frances M. Gorecki
(b) Address 2719 Fait Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/48 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cem
Location Dundalk Ave

18 (a) Funeral director Stephen Feathowstone Inc
(b) Address 1000 S Kenwood Ave

19 (a) APR 15 1948 (Date rec'd by registrar) (b) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1948 at 5.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 3 1948 to April 13 1948, and that I last saw him alive on April 12 1948.

Immediate cause of death	Duration
Laennec's fatty cirrhosis of the liver	?
Due to Chronic parenchymatous nephritis	?
Due to Chronic hemorrhagic gastritis ?	
Other Conditions Myocardial insufficiency 2 wks	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. B. Bronushas, M.D.
Address 3037 O'Donnell St Date signed 4-14-48

VS 150

C62274 Overby BALTIMORE CITY HEALTH DEPARTMENT C62274
CERTIFICATE OF DEATH 91a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division
(c) Hospital or institution: Provident 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos 4 dy.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James T. Overby
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	N	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 23, [illegible]

8. AGE:

Years	Months	Days	If less than one day
41	1	20	hr min

9. Birthplace Mecklinburg Va
(Town, county, and state)
10. Usual Occupation Employment Agent
11. Industry or business
FATHER 12. Name James Overby
13. Birthplace Va
MOTHER 14. Maiden Name Carrie Reuter
15. Birthplace Va
16 (a) Informant Mrs. Maggie Lee
(b) Address 1721 Druid Hill Ave.
17 (a) Burial (b) Date thereof April 15, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.
18 (a) Funeral director Mrs. George St. Holland
(b) Address 1631 Druid Hill Ave
19 (a) Apr 15 1948 Huntington Williams, M.D.
(Date received) (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/13 1948, at 2:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/8 1948 to 4/13 1948.
and that I last saw him alive on 4/12 1948.

Immediate cause of death: Myocardial Failure — Duration
Due to Subacute Bacterial Endocarditis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. Preston Grant M.D.
Address 1514 Division Date signed 4/13/48

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G62275

Litkendale

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

Registered No. G62275

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1620 N. Lexington St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 - 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 1620 N. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Corcetta Rodridge

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1881

8. AGE: Years 67 | Months 2 | Days 23 | If less than one day hr. min.

9. Birthplace Crawl, Bermuda (town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Frederick Rodridge

13. Birthplace Bermuda

MOTHER 14. Maiden Name Anne E. ??

15. Birthplace Bermuda

16 (a) Informant Friends: Maryland Baptist

(b) Address 1620 N. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mrs. Lou. G. Stalland

(b) Address 1631 Druid Hill Ave

19 (a) APR 15 1948 (Date rec'd by registrar) (b) Huntington Hollins, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/14/48 at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/12/48 to 4/14/48, and that I last saw h[illegible] alive on 4/13/48.

Immediate cause of death

Accepted 4-7

Due to

Due to Acute Cardiac Failure

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Hollins M. D.

Address 2364 Caroline Date signed 4/15/48

VS 150

G62276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G62276

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Manchester (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles V Greisenstein
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	Married

6 (b) Name of husband or wife Minnie
6 (c) If alive, give age 51 years

7. Birth date of deceased mo., day, yr. 4-21-96

8. AGE: Years	Months	Days	If less than one day
51	11	23	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Insurance Agent
11. Industry or business

FATHER 12. Name	Charles Greisenstein
FATHER 13. Birthplace	Md
MOTHER 14. Maiden Name	Ella Bixler
MOTHER 15. Birthplace	Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 17 1948 (month) (day) (year)
(c) Cemetery or crematory Manchester, Md
Location

18 (a) Funeral director Paul E. Shoemaker Jr
(b) Address 36 W Main St Westminster Md

19 (a) APR 15 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1948, at 11 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 4/13 1948 to 4/14 1948 and that I last saw him alive on 4/14 1948

Immediate cause of death: Anaemia f Pons
Due to Ligation f Basilar artery
Due to Operation removal 7 Acoustic Tumor, left
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 4/11/48
Major findings of operation: Acoustic Tumor Left
of autopsy: Refused

Duration: 2 min

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 4-14-48 at 11:30 A.M.
(c) Where did injury occur? Johns Hopkins Hosp. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital room (Specify type of place) While at work? no
(e) Means of injury Ether anesthesia

23. Signature Arthur Blaney Asher B. King, M.D.
Address Johns Hopkins Date signed 4/16/48

Howard J. Malone, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G62277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 182a

Registered No. G62277

GM. 118920

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Minutes
(e) Length of stay in Baltimore (yrs., mos., or days) 42 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 W Lanvale ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rachel (Roberts) Robinson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 20 1882

8. AGE: Years	Months	Days	If less than one day
65 (66) Yrs.	7	24	hr. min.

9. Birthplace MD. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Thomas
13. Birthplace MD.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location MD

18 (a) Funeral director Geo. A. Kelson
(b) Address 1303 Eastman St

19 (a) APR 15 1948 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-13-48 1948, at 9:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4 - 13 - 1948 to 4-13- 1948 and that I last saw h alive on 4 - 13 - 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 day
Due to Arteriosclerosis, — yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. C. Robinson Jr.
Address Balt. City Hosp. Date signed 4/13/48

G62278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

Registered No. G62278

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give county)

(d) Street No. 1429 McCulloh St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Dorothy Douglas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female Color or race Colored

5 (a) Single, married, widowed, or divorced Married

5 (b) Name of husband or wife Lenwood

5 (c) If alive, give age years

7. Birth date of deceased mo. 1 day 17 yr. 07

8. AGE: Years 41 Months 3 Days 0 If less than one day hrs. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name ? Fields

13. Birthplace ? ?

14. Maiden Name Rachel ?

15. Birthplace ? ?

16. (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/16/48 (Month, day, year)

(c) Cemetery or crematory Mt Auburn

Location Md

18. (a) Funeral director Geo. E. Ellison

(b) Address 1303 Druid Hill Ave

19. (a) APR 15 (Date received by registrar) Washington Wilkinson, M.D. (Registrar)

vs 8:

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-12-48 at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I last attended deceased from 4-11-48 to 4-12-48; and that I last saw ~~her~~ alive on 4-12-48

Immediate cause of death: Rupture of aorta with dissection of aorta and hemopericardium

Due to: hypertension cardio-vascular disease

Duration: hrs.

Other Conditions

Date of operation

Major findings of operation:

Date of autopsy: the above

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at A.M. P.M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature Jos Sisson M. D.

Address Johns Hopkins Hospital Date signed 4/15/48

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G62279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G62279

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1411 Edmondson Ave
(c) Hospital or institution 14-6
(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore yrs. mos. or days Life

2. USUAL RESIDENCE OF DECEASED:
a. State Md b. County
City or town Balto (If outside city or town, write RURAL and give county)
Street No. 1411 Edmondson Ave (If rural, give location)
c. Citizen of foreign country? Yes or No?
If yes, name country

3 (a) FULL NAME Dorothy Broomes Harcum

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife Raymond F
6 (c) If single, give age years

7. Birth date of deceased (mo., day, yr.) 8/31/1912

8. AGE: Years 35 | Months 7 | Days 13 (If less than one day) hrs. min.

9. Birthplace Balto Md (City, county, and state)

10. Usual Occupation N Wife

11. Industry or business

FATHER 12. Name Wm H Broomes
13. Birthplace Md

MOTHER 14. Maiden Name Martha Harris
15. Birthplace Md

16. (a) Informant Raymond Harcum
(b) Address 1411 Edmondson Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/16/48 (month) (day) (year)

(c) Cemetery or crematory Arbutus
Location Md

18. (a) Funeral director Wm E Kelly
(b) Address 1302 Preston St

19. (a) APR 15 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1948 at 10:40 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 4-6 1948 to 4-13 1948, and that I last saw h Cr alive on 4-13 1948

Immediate cause of death: Myocardial Infarction — Duration —

Due to —

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

at autopsy

PHYSICIAN

Underline the cause to which death should be charged under the rules.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, or public place? (Specify type of place) While at work?
(e) Manner of injury
(f) Nature of injury

Signature Franklin Mathias
Address 743 Reisterstown Rd Date signed 4/15/48

V. S. 180

662280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 H

662280
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2819 Englewood ave
(c) Hospital or institution —
(d) Length of stay in hospital or instn. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city of town limits, write RURAL and give name of township)
(d) Street No. 2819 Englewood ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick STOCKMAN.

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 215-09-9739

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mrs Elizabeth Stockman Nee Peterson
6 (c) If living, give age 57 years
7. Birth date of deceased (mo., day, yr.) March 17, 1893
8. AGE: Years 55 | Months 0 | Days 28 | If less than one day — hrs. — min.

9. Birthplace Latvia (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Yacht yard

FATHER
12. Name Ernest Stockman
13. Birthplace Latvia.

MOTHER
14. Maiden Name Elizabeth Stockman
15. Birthplace Latvia.

16 (a) Informant Mrs. Elizabeth Stockman
(b) Address 2819 Englewood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-48 (Month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Road. Baltimore, Md

19 (a) (Registrar's signature) (b) Registrar

MR 15

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14th 1948 at 12:17 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 3rd 1947 to April 14 1948, and that I last saw h[illegible] alive on April 14 1948.

Immediate cause of death: Carcinomatosis. — Duration: 1 year

Due to —

Due to —

Other Conditions —

Autopsy? No. (Include autopsy findings in items 21 or 22)

Date of operation: [illegible] Major findings of operation: Mixed tumor left parotid gland

(a) Carcinomatosis of peritoneum

of stomach

PHYSICIAN

(Underline the name to which death should be charged in case finality.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur: (Specify type of place: Home, farm, industrial, public place, etc.) While at work?
(e) Means of injury

23. Signature A. S. Delfeld M.D.
Address 6210 York Rd Date signed April 17 1948

X

C62281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C62281 Registered No.

V 121 C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Eager St 25
(c) Hospital or institution: South Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 week
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1944 Annapolis Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles W. Mc. Neal.

3 (b) If veteran, name war: None.

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single.

6 (b) Name of husband or wife: —

6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) December 30 - 1910

8. AGE: Years 37 | Months 3 | Days 14 | If less than one day: hr. min.

9. Birthplace Baltimore - Md. (Town, county, and state)

10. Usual Occupation Pipe Fitter.

11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Charles L. Mc. Neal.
13. Birthplace Pennsylvania.

MOTHER
14. Maiden Name Maggie Hilditch.
15. Birthplace Baltimore - Md.

16 (a) Informant Mrs. Charles L. Mc. Neal.
(b) Address 1944 - Annapolis Road.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof April - 16 - 48. (month) (day) (year)
(c) Cemetery or crematory Glen Haven Mem. Cem.
Location Glen Burnie - Md.

18 (a) Funeral director Charles J. Schwab
(b) Address 3512 - Eastern Ave. Baltimore, Md.

19 (a) (Date received by registrar) (b) Registrar

APR 15 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1948 at 8 15 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from April 6 1948 to April 13 1948 and that I last saw him alive on April 13 1948

Immediate cause of death: Uremia — Duration:

Due to Chronic Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Dillon

Address So. Balto Gen Hosp Date signed M. 4-13-48 D.

X

C62282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45B

C62282 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Un Hosp

(c) Hospital or institution:

4-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 237 N. Greene St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Seris

3 (b) If veteran, name war

3 (c) Social Security Account No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	

6 (b) Name of husband or wife Theresa

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Jan 22-1882

8. AGE: Years	Months	Days	If less than one day: hr	min.
66	2	22		

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Fruit dealer

11. Industry or business

FATHER

12. Name Salvatore Seris

13. Birthplace Italy

MOTHER

14. Maiden Name Anna Biocalo

15. Birthplace Italy

16 (a) Informant Theresa Seris

(b) Address 237 N. Greene St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 14-1948 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem

Location 4430 Old Frederick Rd

18 (a) Funeral director Joseph Lazarre Inc

(b) Address 2013 Glenmount Ave

APR 15 1948

(Registered by registrar) Huntington Williams, Registrar

VS 19

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1948, at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1948 to April 14 1948, and that I last saw him alive on April 14 1948.

Immediate cause of death (Respiratory Distress) ??

Due to CA Tongue

Due to metastasis

Other Conditions

(Including pregnancy within 3 months of death)

Date of operation 4/13/48

Major findings of operation: Cancerous lymph glands in neck

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. Benson

Address Un Hosp Date signed 4/14/48 M.D.

G62283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G62283 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 318 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie WAGONER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Col

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 60 | Months | Days | If less than one day: hr. min.

9. Birthplace S C (Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business

FATHER
12. Name Aaron Dial
13. Birthplace S C

MOTHER
14. Maiden Name Sarah Walker
15. Birthplace S C

16 (a) Informant Delores Franklin
(b) Address 4654 Falls Rd

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 4/17/48 (month, day, year)
(c) Cemetery or crematory Laurel
Location Balto County

18 (a) Funeral director Wm A Jackson
(b) Address 946 Bolton Ave

APR 15 1948 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/13/1948, at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection and Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease

Due to

Other Conditions
(Include pregnancy within month of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (What was he doing at time of injury?)
(d) Means of injury

23. Signature George F. Merrill M.D.
Medical Examiner.
Date signed 4/14/48

VS 151

G62284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G62284

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp 13 DH
(d) Length of stay in hospital or inst. (yrs., mos., or days) DH
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Balto
(If outside city or town limits write RURAL and give town)
(d) Street No. 3306 Elm Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin F Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 15 1863

8. AGE: Years	Months	Days	If less than one day: hr	min
84	3	27		

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name .....
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Lillian E Crowther
(b) Address 3306 Elm ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 16 48 (month) (day) (year)

(c) Cemetery or crematory Moreland Mem. Pk.
Location Baltimore

18 (a) Funeral director Frank H Seitz
(b) Address 814 N 36 St

19 (a) ..... Huntington Williams, MD
(Date received by registrar) Registrar

APR 16 1948

Rec'd

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1948, at 8 45 M

21. I certify that I took charge of the remains described above, held an Aug & Insp thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐, and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular disease

Due to disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Huntington Williams M.D.
Medical Examiner
Date signed 4/14/48

G62285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G62285 Registered No. 58a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Prince Georges

(c) City or town College Park

(d) Street address (If outside city or town limits, write RURAL and give town) National Trailer Ct Hwy (If rural give location)

(e) Citizen of foreign country? (Yes or No?)

If yes, name country

3 (a) FULL NAME Iris S. Drey

3 (b) If veteran, name war

3 (c) Social Security Account No

4 Sex Female 5 Color or race White 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. 2-16-39

8. AGE: Years 9 Months 1 Days 27 If less than one day hr. min

9. Birthplace Alabama (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name O. K. Drey

13. Birthplace Ala.

14. Maiden name Audrey Whaley

15. Birthplace Ala.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 16 1948 (month) (day) (year)

(c) Cemetery or crematory Washington Nat. Cemetery

Location Suitland Md.

18 (a) Funeral director W. W. Chandlee

(b) Address Washington D.C.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-13 1948 at 10 00 M

21. I certify that death occurred on the date above stated, that I attended deceased from 3-M-48 to 4-13 1948.

and that I last saw h alive on 4-13 1948

Immediate cause of death Cardiac failure

Due to Rheumatic heart disease

Due to Pericardial effusion

Due to 3 years duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: above -

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?) (Specify type of place)

(e) Means of injury

23. Signature John S. Morris M. D.

Address Johns Hopkins Hosp. Date signed 14 Apr 48

VS (9)

C62286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

Registered No. C62286

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1311 Hollins St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-3
(e) Length of stay in Baltimore (yrs., mos., or days) about 45yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town.)
(d) Street No. 1311 Hollins St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Catherine M. Shanahan

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Martin P.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15th 1890

8. AGE: Years	Months	Days	If less than one day
57	9	30	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation House Work
11. Industry or business at Home

FATHER
12. Name Unknown
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace Ireland

16 (a) Informant Mrs Mary Scallio
(b) Address 1216 Hollins St.

17 (a) Burial (Burial, cremation, or removal) b. Date thereof 4/16/48 (months) (day) (year)
(c) Cemetery or crematory New Cathedral Cem. Location 4300 Old Frederick Rd.

18 (a) Funeral director John J. Gorman & Son
(b) Address 901-03 Hollins St.

19 APR 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14th 1948 at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948 to Apr 14 1948 and that I last saw h[illegible] alive on 4/14/48

Immediate cause of death: Nephritis — Duration 1 year

Due to Uraemia — 3 days

Due to

Other Conditions

(Include pregnancy within 3 months of death.)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(d) Means of injury

23. Signature Walter D. Thomas, M.D.
Address 1012 Edmondson Ave. Date signed 4/15/48

VS 180

G62287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

111a

Registered No. G62287

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1110 Scott St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 + 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1110 Scott St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie A. Languth

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Charles
6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.): Mar 17th 1876

8. AGE: Years 72 | Months - | Days 28 | If less than one day: hr. ____ min. ____

9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual Occupation: Housework
11. Industry or business: at Home

FATHER
12. Name: John Hohn
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Josephine Hohn
15. Birthplace: Baltimore Md.

16 (a) Informant: Mrs Richard H. Brown
(b) Address: 1110 Scott St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/48 (month) (day) (year)
(c) Cemetery or crematory: London Park Cem.
Location: 3801 Frederick Rd.

18 (a) Funeral director: John J. Cowan & Son
(b) Address: 203 Hollins St.

19 (a) ____ (Date rec'd by registrar) (b) Hunting for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14th 1948 at 1.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 3 1948 to April 17 1948, and that I last saw him alive on April 17 1948.

Immediate cause of death: Pulmonary Embolism — Duration: Sudden
Due to: Gangrene right leg — 5 days
Due to: Thrombosis right femoral Artery — 7 days
Other Conditions: Hernia abdominal and Intestinal obstruction — ? 20 yrs
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: John P. Ulrich Jr
Address: 122 N Wash Blvd Date signed: 4/23/48

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D62288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 062288

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1614 KINGSWAY RD.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE TIME

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE 1
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1614 KINGSWAY RD.
(If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) **FULL NAME** LOUIS HERMAN MOEHLER

3 (b) If veteran, name war: NONE.

3 (c) Social Security Account No. 215-01-1582

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife: SINGLE.

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) FEB. 14, 1879

8. AGE: Years: 69 | Months: 2 | Days: 0 | If less than one day: hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation DESIGNER & CUTTER

11. Industry or business MEN'S CLOTHING

FATHER
12. Name HERMAN MOEHLER
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARY SCHINNEMAN
15. Birthplace GERMANY

16 (a) Informant MRS. AIMEE JONES (SISTER)
(b) Address 1614 KINGSWAY RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/17/48 (month) (day) (year)
(c) Cemetery or crematory MEADOWRIDGE
Location HOWARD CO. MD.

18 (a) Funeral director WM. J. TICKNER & SON
(b) Address WOLFE ST. MD.

19 APR 15 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 14, 1948. at 11:45 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from MAR. 27 1948 to APR 14 1948. and that I last saw HIM alive on APRIL 13, 1948.

Immediate cause of death: CORONARY THROMBOSIS — Duration: 2½ HRS

Due to ARTERIO SCLEROTIC DEGENERATION — 2 YRS.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation NONE.

Major findings of operation:

of autopsy: NONE.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William Karfgin M. D.
Address 4210 HACK KNOWN BLVD Date signed 4-14-48

VS 150

G62289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G62289

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5114 Norwood Road
(c) Hospital or institution

(d) Length of stay in hospital or inst. yrs., mos., or days 27-11
(e) Length of stay in Baltimore yrs. mos. or days

2. USUAL RESIDENCE OF DECEASED:
a State Md. b County
c City or town Baltimore (If outside city or town limits, write R.F.D. and give town.)
d Street No. 5114 Norwood Road (If rural, give location)
e Citizen of foreign country? Yes or No? If yes, name country

3. a FULL NAME Charles G Hare
3. b If veteran, name war
3. c Social Security Account No.

4. Sex Male
5. Color or race White
6. a Single, married, widowed, or divorced Married
6. b Name of husband or wife Rena B Hare
6. c If alive, give age years
7. Birth date of deceased mo., day, yr. July 2 1885
8. AGE: Years 62 Months 9 Days 11 If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Metal Stamping

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16. a Informant Rena B. Hare
b Address 5114 Norwood Road
17. a Burial (Burial, cremation, or removal) b Date thereof April 16 1948 (months) (day) (year)
c Cemetery or crematory London Park
Location Frederick Road
18. a Funeral director John A Moran
b Address 3600 E Baltimore St
19. (a) APR 15 1948 (b) Baltimore Md Address 3010 Brantley Rd

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1948 at 2.44 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 2 1948 to April 13 1948 and that I last saw him alive on April 2 1948 10 A.M.

Immediate cause of death: Cardiac failure
Bronchial Asthma & Emphysema
Due to Penicillin Shock

Duration
2 weeks

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
a) Accident, suicide, or homicide
b) Date of occurrence at M
c) Where did injury occur? (City or town, county, State)
d) Did injury occur about home, on farm, industrial place, or public place? While at work? (Specify type of place)
e) Means of injury

23. Signature John W. Clift M. D.
Address 3010 Brantley Rd Date signed 4 13 48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

62290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 170C

62290

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp. 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (County) Balto.
(b) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1139 Scott St.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara E. Pohe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	widow

6 (b) Name of husband or wife Frederick Wm.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/5/1872

8. AGE: Years	Months	Days	If less than one day: hr.	min.
68	8	5		

9. Birthplace Buffalo, N.Y. (Town, county and State)
10. Usual Occupation home duties
11. Industry or business

FATHER
12. Name Adam Presser
13. Birthplace Md

MOTHER
14. Maiden Name Mary Baker
15. Birthplace U.S.

16 (a) Informant Henry F. Pohe
(b) Address 757 Edgewood Boul.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 13/48

(c) Cemetery or crematory Woodlawn
Location Gwynn Oak Ave

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) (b) Huntington, W. Va. (Registrar)

APR 15 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13/1948 at 8:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy/Inspection/Inquiry Inspection & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐, and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fractured skull; intracranial hemorr.; fract. of leg bones; brush burns & bruises

Due to

Other Conditions
(Include pregnancy within three months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following 21/1

(a) Date of injury 4/13/48 1:35 P.M.
(b) Where did injury occur? Scott & Hamburg Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public street (Specify) (Whether in work) No
(d) Means of injury Pedestrian struck by #6 Bus

23. Signature Howard J. Madeira M.D.
Medical Examiner
Date signed 4/14/48

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G62291

G62291 B.M.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rt-13-Cherry Garden.zone-21
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James, Cook

3 (b) If veteran, name war

3 (c) Social Security Account No. 234-10-8246

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Maria
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 11, 1908

8. AGE: Years	Months	Days	If less than one day
39	6	3	hr. min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John W. Cook
13. Birthplace West Virginia

MOTHER
14. Maiden Name Elizabeth Roles
15. Birthplace West Virginia

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4-15-48 (month) (day) (year)

(c) Cemetery or crematory
Location Beckley, West Virginia

18 (a) Funeral director J. Brudzinski
(b) Address 1402 Eastern Ave Rd

19 (a) APR 15 1948 (Date rec'd by registrar) (b) Cunningham Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14. 19 48 at 7:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-5-4 19 48 to 4-14-4 19 48, and that I last saw him alive on 4-14 19 48.

Immediate cause of death Chronic glomerulonephritis — Duration 6 yrs

Due to

Due to

Other Conditions Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. T. Bonfoed M. D.
Address Balt. City Hosp. Date signed 4-14-48

VS 150

G62292

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1948

G62292 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 324 Hawthorn road
(c) Hospital or institution: 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 63 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 324 Hawthorn road (If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country -------

3 (a) FULL NAME Ella H. McGinley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife James Edw. McGinley
6 (c) If alive, give age -- years

7. Birth date of deceased mo., day, yr. April 7, 1922

8. **AGE:** Years 63 | Months -- | Days 6 | If less than one day -- hr. -- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business -------

FATHER
12. Name Edward Mulligan
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Fuhrer
15. Birthplace Maryland

16 (a) Informant Mrs. Ethel M. Sexton
(b) Address [illegible]

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/48 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Md.

18 (a) Funeral director [illegible]
(b) Address 801 N. Calvert Street

APR 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS (5)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1948, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 3 1948 to April 12 1948 and that I last saw h-- alive on April 12 1948

Immediate cause of death: Cardio-vascular hypertension disease — Duration: 6 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work)
(e) Means of injury

23. Signature Homer L. Woodcock M. D.
Address 2108 E. Fayette Date signed 4/14/48

G62293 BALTIMORE CITY HEALTH DEPARTMENT G62293
CERTIFICATE OF DEATH 1948 Registered No.

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2316 N Calvert
(c) Hospital or institution: at Home 12-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2316 N. Calvert St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Latimer Baron

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug-13-1866

8. AGE: Years 81 | Months 8 | Days 1 | If less than one day: hr. min.

9. Birthplace Illinois (Town, county, and state)
10. Usual Occupation retired member of
11. Industry or business Goucher College Faculty

FATHER
12. Name Constant Constantin
13. Birthplace probably Illinois

MOTHER
14. Maiden Name Louisa Latimer
15. Birthplace probably Illinois

16 (a) Informant Miss M. Cooley - friend
(b) Address Goucher College - Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr-16-48 (month) (day) (year)
(c) Cemetery or crematory ?
Location Abingdon - Illinois

18 (a) Funeral director Eckhardt Mortuary
(b) Address 108 W Mt. Royal Ave.

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 14 1948 at 8:13 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 to Apr 14 1948
and that I last saw h[illegible] alive on Apr 14 1948.

Immediate cause of death: Myocardial Failure — Duration: 2 days
Due to: Pulmonary Edema — 2 days
Due to: Arteriosclerosis Myocarditis — Indefinite
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathaniel M Beck M. D.
Address 100 E. 23rd St Date signed Apr 15-48

VS 150

G62294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 124a

X G62294 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address N. Calvert Street

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2 wks

2. USUAL RESIDENCE OF DECEASED:

(a) State Penn (b) County Lackawanna

(c) City or town Scranton (If outside city or town limits, write RURAL and give town)

(d) Street No. 223 Schlager Street (If rural give location)

(e) Citizen of foreign country? (Yes or No) No

If yes, name country

3 (a) FULL NAME Dr. Ezra Yocum Harrison (Dr. Ezra Yocum Harrison)

3 (b) If veteran, name war ____ Social Security Account No. ____

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-15 1948, at 7 10 AM

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

21. I certify that death occurred on the date above stated; that I attended deceased from 4-7 1948, to 4-15 1948, and that I last saw h[illegible] alive on 4-15 1948

6 (b) Name of husband or wife Minnie R. Harrison

6 (c) If alive, give age ____ years

7. Birth date of deceased mo., day, yr 10-12-1870

8. AGE: Years 77 | Months 6 | Days 3 | If less than one day: hr ____ min ____

Duration
24 hrs
4-5 yrs
2 wks ?
25 yrs

Immediate cause of death Coronary Occlusion

Due to Hypertension

Due to Uremia Bilateral kidney stones

Other Conditions Syphilis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

9. Birthplace Penn (Town, county, and state)

10. Usual Occupation Dentist

11. Industry or business

FATHER 12. Name Joseph H. Harrison

13. Birthplace Penn

MOTHER 14. Maiden Name Mary Glasco

15. Birthplace Penn

16 (a) Informant Stephen C. Harrison (son)

(b) Address 3206 Overland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 17 48 (month) (day) (year)

(c) Cemetery or crematory Abington Hills

Location Scranton, Penna.

18 (a) Funeral Director Stewart & Mowen Company

(b) Address 125 W. North Ave, City

APR 15 1948 (Date rec'd by registrar) Registrar

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (While at work)

(e) Means of injury

23. Signature William R. Gut M. D.

Address Mercy Date signed 4-15-48

VS 150

Dup. G62295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G62295

Registered No. 12/a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address ..... N. Broadway

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-1 6 da

(e) Length of stay in Baltimore (yrs., mos., or days) -?-

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 316 Park Ave (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Fung Shun (Shun Fung)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White Chinese	-?-

6 (b) Name of husband or wife -?-

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12-22-07

8. AGE: Years	Months	Days	If less than one day
40	3	24	hr. min.

9. Birthplace probably U.S.A. (Town, county, and state)

10. Usual Occupation Laundry

11. Industry or business

FATHER 12. Name could not ascertain

13. Birthplace could not ascertain

MOTHER 14. Maiden Name could not ascertain

15. Birthplace could not ascertain

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-48 (month) (day) (year)

(c) Cemetery or crematory Lorraine

Location Baltimore

18 (a) Funeral director Stewart Memorial

(b) Address 108 W. Mount Ave.

19 ARR (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-15 1948 at 702 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-4 1948 to 4-15 1948, and that I last saw h[illegible] alive on 4-15, 1948.

Immediate cause of death Postoperative surgical shock

Due to Nephrectomy, Rt

Due to

Other Conditions Pyelonephritis

(Include pregnancy within 3 months of death)

Date of operation 4-14-48

Major findings of operation: Atrophic unaffected kidney

of autopsy:

Duration
3 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work) (Specify type of place)

(e) Means of injury

23. Signature Perry Blandon M. D.

Address Johns Hopkins Hosp Date signed 4-15-48

VS 150

C62296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9-7

C62296

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 9-8
(b) Street address
(c) Hospital or institution: Union Memorial Hospital - D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 525 East 21st Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Susan Deehring

3 (b) If veteran, name war: --

3 (c) Social Security Account No. --

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: William F. Deehring

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 3, 1863

8. AGE: Years: 84 Months: 4 Days: 12 If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: --

11. Industry or business

FATHER
12. Name: Christian Spuck
13. Birthplace: Germany

MOTHER
14. Maiden Name: Caroline Walters
15. Birthplace: Germany

16 (a) Informant: Arthur H. Deehring
(b) Address: 525 East 21st Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 4/17/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Maryland

18 (a) Funeral director: Wm. Cook, Inc.
(b) Address: 1217 St. Paul Street

19 APR 16 1948 (Date rec'd by registrar) Hunting for Williams MF (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1948 at 11 A. M

21. I certify that death occurred on the date above stated that I attended deceased from 11-23 1942 to 4-15 1948 and that I last saw deceased alive on 4-15 1948

Immediate cause of death: Coronary occlusion

Due to: Cardiovascular disease

Due to:

Other Conditions: —

Duration

Date of operation: —

Major findings of operation: —

PHYSICIAN

(Underline the cause to which death should be charged statistically)

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work)
(e) Means of injury

23. Signature: Jack J. Singer
Address: 50 E. North Ave. Date signed: 4-15-48

VS (5)

G62297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G62297

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7-18
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
a. State Md b. County
c. City or town Balto (If outside city or town limits, write RURAL and give town)
d. Street No. 5261 St. Charles Av (If rural give location)
e. Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lepper, Elizabeth
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed, or divorced~~
Female	White	Married

6 (b) Name of husband ~~or wife~~ John F. Lepper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 17th 1890

8. AGE: Years	Months	Days	If less than one day: hr.	min
58	0	27		

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name Ludwig Kellerman
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace "

16 (a) Informant John F. Lepper
(b) Address 5261 St. Charles Av
17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/17/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. Md.
Location
18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St
19. Filed APR 16 1948 Huntington Williams M.D. (Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 April 1948 at 5 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 18 April 1948. to 14 April 1948. and that I last saw her alive on 14 April 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Diabetes Mellitus	
Due to Arteriosclerosis Generalized.	
Other Conditions gangrene, right leg. (Include pregnancy within 3 months of death)	

Date of operation 4-12-48
Major findings of operation: Cellulitis & gangrene rt. leg
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Laham M. D.
Address Franklin Sq Hosp. Date signed 14 April '48

X

G62298

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 193D

G62298
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp. 7-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) born here.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 145 Spring St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Daisy Lee Deal

3 (b) If veteran, name war: —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife: Edgar Lee Deal
6 (c) If alive, give age 2 years

7. Birth date of deceased (mo., day, yr.) Oct 4th 1882

8. AGE: Years	Months	Days	If less than one day: hr.	min.
65	6	5		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name James Lewis
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Eva Drek
15. Birthplace Balto. Md.

16 (a) Informant Edgar L. Deal
(b) Address 145 Spring St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/17/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. Md.
Location

18 (a) Funeral director William "Cook Inc.
(b) Address 1217 St. Paul St.

4/16 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 14 1948, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10/ 1948 to 4/14 1948.
and that I last saw her alive on 4/14 1948.

Immediate cause of death Respiratory Failure — Duration

Due to Cerebral Hemorrhage

Due to Hypertensive C.V.D.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at .M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Vols. Fitzpatrick M.D.
Address St. Joseph Hosp. Date signed 4/16/48

V S 150

C62299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 432a

Registered No. C62299

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Puritan St
(c) Hospital or institution: 13-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city, town limits, write RURAL and give town)
(d) Street No. 700 Puritan St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth M. Henkel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed or divorced~~
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 26th 1871

8. AGE: Years	Months	Days	If less than one day
76	5	18	9 hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Ex Nurse

11. Industry or business Self

FATHER
12. Name Charles Henkel
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Shoemaker
15. Birthplace Germany

16 (a) Informant Mrs. E. Dorie
(b) Address 2714 Matthews St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/16/48 (month) (day) (year)
(c) Cemetery or crematory Balto.
Location Md.

18 (a) Funeral director William Cook Jr. Co.
(b) Address 1217 E. Paul St.

19 Filed APR 16 1948 (Date filed by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14th 1948. 1:30 p.m.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/11 1947 to 4/14 1948.
and that I last saw h~~im~~ alive on 4/13 1948.

Immediate cause of death Cerebral Hem.
Due to arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

Duration 8 hrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert H. Henkel M.D.
Address 2020 N. Charles Date signed 4/15/48

VS 150

G62300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G62300

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. J. (b) County
(c) City or town Jersey City (If outside city or town limits, write RURAL and give town)
(d) Street No. 131 Franklin St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dorothy McClouse

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr 1-5-48

8. AGE: Years | Months: 3 | Days: 18 | If less than one day: hr. min.

9. Birthplace New Jersey (town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Albert Clouse
13. Birthplace N. J.

MOTHER 14. Maiden Name Mary Hawkins
15. Birthplace N. J.

16 (a) Informant Mary M. Clouse
(b) Address JOHNS HOPKINS HOSPITAL Jersey City, N. J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 18/48 (month) (day) (year)
(c) Cemetery or crematory Hamburg Cemetery
Location HAMBURG, N. Y.

18 (a) Funeral director John D. Mitchell Sons
(b) Address 1400 Eutaw Place Huntington Williams Co.

APR 20 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1948, at 3 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/14 1948 to 4/15 1948 and that I last saw her alive on 4/15 1948.

Immediate cause of death: Transportation from Great Vessels — Duration

Due to

Due to

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Edmonds

Address J. H. H. Date signed 4-15-48 M D

VS 150

GG2301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. GG2301

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3507 Reisterstown Road
(c) Hospital or institution: 15-17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3507 Reisterstown Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia Chenkin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Abraham

6 (c) If alive, give age: 1883 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 65 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: House Wife

11. Industry or business

FATHER
12. Name: Hyman Rozinsky
13. Birthplace: Russia

MOTHER
14. Maiden Name: Ida Bobinskin
15. Birthplace: Russia

16 (a) Informant: Abraham Chenkin
(b) Address: 3507 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: April 16, 1948 (month) (day) (year)
(c) Cemetery or crematory: Work Men Circle Cem
Location: German Hill Road

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North ave

19 (a) APR 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1948 at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1947 to April 15, 1948.
and that I last saw her alive on April 14, 1948.

Immediate cause of death: Cancer of the Stomach — Duration: 6 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel V. Jonyaker M.D.
Address 3431 Clark Heights Ave Date signed April 15 1948

C62302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C62302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 Chilton St
(c) Hospital or institution: 96
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 64yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Chilton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Adolph H Schlag

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Louise Schlag
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 9 1856

8. AGE: Years	Months	Days	If less than one day
81	6	6	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Baker
11. Industry or business Retired

FATHER
12. Name Aug H Schlag
13. Birthplace Germany

MOTHER
14. Maiden Name Henrietta Voigt
15. Birthplace Germany

16 (a) Informant Adolph H Schlag
(b) Address 3319 Wasaria Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1937 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2201 Orleans St

19 (a) APR 16 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1948 at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1937 to April 15 1948 and that I last saw him alive on 4/15/1948

Immediate cause of death Myocardial Degeneration — Duration 6 mo

Due to Arteriosclerosis — Duration 7 yr

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H H Kemmann M. D.
Address 1710 E Fayette St Date signed 4/16/48

VS 150

C62306-A

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No. C62303

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 16-5
(b) Street address 2416 Edmondson Ave
(c) Hospital or institution: Md General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7416 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Erck

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Mabel Erck

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 20-1886

8. AGE: Years 61 | Months 5 | Days 7 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Credit Manager

11. Industry or business

FATHER 12. Name Charles Erck
FATHER 13. Birthplace Balto

MOTHER 14. Maiden Name Annie Walk
MOTHER 15. Birthplace Balto

16 (a) Informant Miss Hilda Erck
(b) Address 602 N Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 17 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2005 Aliceanna St

19 (a) Apr 16 1948 (Date rec'd by local registrar) (b) Municipal Building, Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-14 1948 at 8 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-27 1948 to 4-14 1948 and that I last saw h me alive on 4-14 1948

Immediate cause of death
Pulmonary Embolism — Duration 15 minutes

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 3-30-48

Major findings of operation: left inguinal hernia

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene A. Pekarskas M. D.
Address Maryland Bank Bldg Date signed 4-14-48

VS 150

C62304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C62304

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3010 White Ave
(c) Hospital or institution: 27-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3010 White Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA Suehle

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Emil Suehle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3

8. AGE: Years	Months	Days	If less than one day: hr	min
80	1	11		

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Dont Know
13. Birthplace Germany

MOTHER
14. Maiden Name Dont Know
15. Birthplace Germany

16 (a) Informant Mrs Clara Heckmon
(b) Address 713 E 37th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 17 (month, day, year)
(c) Cemetery or crematory Baltimore Cemetery Co
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (Date received by registrar) APR 16 1948 (Huntington Williams, M.D. Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1948 at 11:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy / Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (While at work?)
(d) Means of injury

23. Signature Earl L Boyer M.D. (Medical Examiner)
Date signed 4-15-48

662305

BALTIMORE CITY HEALTH DEPARTMENT

JL - 118712 CERTIFICATE OF DEATH 937

Registered No. 662305

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 5, 1
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Canal St - Apt. B1 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Jones

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: C
6 (a) Single, married, widowed, or divorced: ?
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 12 . ?
8. AGE: Years 79 ? Months 3 Days 2 If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward Murray
13. Birthplace Md.

MOTHER
14. Maiden Name Agnes ?
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location

18 (a) Funeral director Joseph B. Lord, Jr.
(b) Address 1364 N. Central Ave

APR 16 1948 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1948, at 4.50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1948 to April 14 1948, and that I last saw her alive on April 14 1948.

Immediate cause of death Generalized Arteriosclerosis & Arteriosclerotic cardiovascular disease — Duration

Due to

Due to

Other Conditions
(Include pregnancy within three months of death)

Date of operation 4/8/48

Major findings of operation: Arteriosclerosis Gangrene of foot

If autopsy do above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. S. Kantos M. D.
Address Baltimore City Hosp Date signed 4/15/48

VS 150

652306

AB- 11806 -

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 7/12 B

Registered No. 652306

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 14yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 30 N. Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Anderson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1-1899

8. AGE: Years	Months	Days	If less than one day
49 48	-	11	hr. min.

9. Birthplace Virgin Islands (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name John Anderson (D
13. Birthplace ?

MOTHER
14. Maiden Name Mary ? (D
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/17/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. County, Md.

18 (a) Funeral director Joseph D. Locke, Jr.
(b) Address 1364 N. Central Ave

19 (a) APR 16 1948 (Date received by registrar) (b) Huntington Williamsville, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12- , 1948 , at 2.15AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-10- 1948 , to 4-12- 1948 , and that I last saw h alive on 19 .

Immediate cause of death Bel. Tbc Adv. Tbc — Duration 5 yrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John R. Morrison
Address 6615 Alt Hop Date signed 7/13/48 M.D.

VS - 180

G62307

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1948

Registered No. G62307

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1525 Myrtle Ave
(c) Hospital or institution: 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1525 Myrtle Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: MARY ELIZABETH WICKS

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: LLOYD

6 (c) If alive, give age: years

7. Birth date of deceased mo., day, yr: 12/11/1870

8. AGE: Years: 77 | Months: 4 | Days: 3 | If less than one day: hr min

9. Birthplace Warrenton, Va, (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name ?
13. Birthplace Va.

MOTHER
14. Maiden Name: Elizabeth Gillison
15. Birthplace: Warrenton, Va.

16 (a) Informant: Andrew G. Wicks
(b) Address: 1730 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk.
Location Balto. County, Md.

18 (a) Funeral director: Charles G. Cooper
(b) Address: 510-12 N. Carrollton Ave

APR 16 1948 (Date rec'd by registrar) Hunting for Indiana MF

VS 15)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1948, at 6:30 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Jan. 20 1948, to April 14 1948, and that I last saw her alive on April 10 1948.

Immediate cause of death: Myocardial degeneration — Duration: ?
Due to: Arteriosclerosis — ?
Due to: Senility
Other Conditions: Senile Cataracts — 4 yrs.

(Include pregnancy within three months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Wallis Sherwood
Address 201 N. Carey
Date signed 4/15/48 M. D.

G62308

BALTIMORE CITY HEALTH DEPARTMENT

JL -118853

CERTIFICATE OF DEATH / 93D

Registered No. G62308

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 16-2
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1322 Mosher St - 17
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Louis Roberts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1907

8. AGE: Years	Months	Days	If less than one day
40	5	25	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Francis Roberts
13. Birthplace Md.

MOTHER
14. Maiden Name Laura Mapp
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 4/17/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A.County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 Carrollton Ave

19 APR 16 1948 Courtesy for Mitchell, M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1948, at 2.10A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1948 to April 14 1948, and that I last saw him alive on April 14 1948.

Immediate cause of death

Cardiac Failure

Due to Hypertensive Cardiovascular Disease

Due to

Other Conditions Gastro-intestinal Bleeding
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above - Dr. Copeland Mitchell

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. K. Scarborough, M.D.

Address Balto City Hosp Date signed 4-14-48

C62309

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

C62309 Registered No.

131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 571 Dolphin St.
(c) Hospital or institution: 17-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 571 Dolphin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Lawrence

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Hattie Lawrence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1893

8. AGE: Years	Months	Days	If less than one day
55	-	1	hr. min.

9. Birthplace West Indies (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Jamaica

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Hattie Lawrence
(b) Address 571 Dolphin Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) APR 16 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13, 1948 at 9h M

21. I certify that death occurred on the date above stated; that I attended deceased from July 4 1947 to 4/13 1948 and that I last saw h[illegible] alive on 4-11 1948.

Immediate cause of death: Hypertension, Sarcoma - Renal
Vascular — Duration: 9 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature H J. Healy
Address 1 W N Pine Date signed 4/16/48

662310

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 662310 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert St., Balto

(c) Hospital or institution Mercy Mem'l Hospl

(d) Length of stay in hospital or inst. yrs. mos. or days 1 day

(e) Length of stay in Baltimore yrs. mos. or days

2. USUAL RESIDENCE OF DECEASED

a. State Md b. County [illegible]

c. City or town Baltimore

d. Street No. 7800 Chestnut Ave., Balto

e. Citizen of foreign country? No Yes or No?

If yes, name country

3 (a) FULL NAME Elizabeth Leschinsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed or divorced

6 (b) Name of husband or wife [illegible]

6 (c) If alive, give age years

7. Birth date of deceased mo. day yr. [illegible]

8. AGE: Years 77 Months 9 Days If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county and state)

10. Usual Occupation None

11. Industry or business -

FATHER 12. Name Jacob Schwartz

13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Katherine Schmidt

15. Birthplace Baltimore

16. (a) Informant Mrs Mary Bangert

(b) Address 7800 Chestnut Ave., Balto

17. (a) Burial [illegible] (b) Date (burial) [illegible]

(c) Cemetery or crematory [illegible]

Location [illegible]

18. (a) Funeral director [illegible]

(b) Address [illegible]

(Date rec'd by registrar) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1948 at 11 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 13 1948 to April 14 1948; and that I last saw her alive on April 14 1948

Immediate cause of death: Cerebral hemorrhage — Duration 2 hr.

Due to: Hypertension & Sclerosis — 7 yr.

Due to:

Other Conditions:

Date of operation:

Major findings of operation:

22. Autopsy? Cerebral hemorrhage

23. If death was due to external causes, fill in the following:

(a) Accident, suicide or homicide? accident

(b) Date of injury? April 2 1948

(c) Where did injury occur? Baltimore (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Yes or No? (If not at work) No

(e) Manner of injury? Fell down stairs

(f) Nature of injury? Fell down stairs

24. Signature [illegible] M.D.

Address [illegible] Date signed 4/15/48

PHYSICIAN

Underline the cause to which death should be charged statistically

062311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

062311
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1-1
(c) Hospital or institution: J. H. H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. County Balto
(b) City or town Balto.
(c) Street No.
(d) Citizen of foreign country? Yes or No?
If yes, name country

3 (a) FULL NAME George Konvarski (Kordonski)
3 (b) If veteran, name war
3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1948 1:40 P.M.

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Helen
6 (c) If alive, give age

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy inspection or inquiry found that said deceased came to N.N. death on the day stated above, and death in my opinion resulted from natural causes, accident, homicide, undetermined, and that the causes of death were

7. Birth date of deceased (mo., day, yr.)
8. AGE: Years 59 Months Days (If less than one day, hrs. or min.)

IMMEDIATE CAUSE OF DEATH
Coronary artery disease

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation can maker
11. Industry or business canning Co.

FATHER
12. Name unknown
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

Due to

Other Conditions

16. (a) Informant Mrs Joseph F Schultz
(b) Address 1800 Elliott st.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-48
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Ave

18. (a) Funeral director Stephen J. Fiakowski & Co.
(b) Address 800 S. Kenwood Ave

19. APR 16 1948 (Date rec'd by registrar) (b) Contractor for Williams, M.D. Registrar

22. If an external cause was primary or was contributing cause of death, fill in the following
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place or in public place?
(d) Means of injury
23. Signature Carl W. Rogers M.D. Medical Examiner
Date signed 4-15-48

VS 181

662312

DC. 48-0736

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

662312
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland E
(b) Street address
(c) Hospital or institution Union Memorial Hospital
(d) Length of stay in hospital or inst. ~~years~~ ~~months~~ or days 12
(e) Length of stay in Baltimore ~~years~~ ~~months~~ or days 12

2. USUAL RESIDENCE OF DECEASED
a. State Maryland b. County —
c. City or town Baltimore
(If outside city limits or town limits, write RURAL and give town)
d. Street No. 1900 Patterson Park Ave
(If rural give location)
e. Citizen of foreign country? DO Yes or No)
If yes, name country —

3 (a) FULL NAME Margaret Mary Ashe

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. April 3, 94

8. AGE: Years — | Months — | Days 12 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Edward Ashe Jr
13. Birthplace Balto Md

MOTHER
14. Maiden Name Catherine Ruth Sankey
15. Birthplace Balto Md

16 (a) Informant hospital records
(b) Address

17 (a) Burial (b) Date thereof 4-16-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Hartford Rd

18 (a) Funeral director John A. Morar
(b) Address 2020 E. Balt. St.

19 (a) APR 15 1948 (b) Huntington Nottingham M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-15 1948 at 3:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-2 1948 to 4-15 1948, and that I last saw her alive on 4-13 1948.

Immediate cause of death pneumonia — Duration

Due to Term pregnancy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature E B Chambers
Address Union Memorial Hosp Date signed 4/15/48

X

662313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √124B

Registered No. 662313

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 816 W. North Avenue
(c) Hospital or institution: 13-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 816 W. North Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME C. Geraldine Vallaire

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Louis E. Vallaire
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/29/1898

8. AGE: Years	Months	Days	If less than one day
49	4	13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name John Bauer
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sadie Connors
15. Birthplace Baltimore, Md.

16 (a) Informant Louis E. Vallaire
(b) Address 816 W. North Avenue

17 (a) Burial (b) Date thereof 4/16/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Baltimore, Md.

19 APR 16 1948
(Date rec'd by registrar) Deputy for Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12, 1948, at 2 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 18, 1948, to April 12, 1948, and that I last saw her alive on April 12, 1948.

Immediate cause of death	cardiac failure	Duration Feb. 18,
Due to	cirrhosis of the liver associated with empyema of the	
Due to	gall bladder	
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation February 26, 1948
Major findings of operations: empyema of the gall bladder, cirrhosis of liver
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George A. Kupp M. D.
Address 3030 Edmondson Avenue Date signed 4/14/48

VS 150

G62314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

G62314 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 27-15

(a) Baltimore City, Maryland

(b) Street address 2211 W. ROGERS Ave

(c) Hospital or institution Home for the Aged of the Meth. Church

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 YRS

(e) Length of stay in Baltimore (yrs., mos., or days) 83 YRS

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town BALTO. (If outside city or town write RURAL and give town)

(d) Street No. 2211 W ROGERS Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME THEODORE STEINRUCKEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	WIDOWER

6 (b) Name of husband or wife LUCY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-18-1864

8. AGE: Years	Months	Days	If less than one day
83	8	27	hr. min.

9. Birthplace BALTO., MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name JOSEPH J STEINRUCKEN

13. Birthplace GERMANY

MOTHER 14. Maiden Name PAULINE HILDEBRAND

15. Birthplace GERMANY

16 (a) Informant MRS. MAMIE B. FISHER

(b) Address 2211 W. ROGERS Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/48 (month) (day) (year)

(c) Cemetery or crematory WOODLAWN

Location BALTO CO. MD.

18 (a) Funeral director WM J. TICKNER & SONS

(b) Address BALTO., MD.

19 (a) APR 16 1948 (Date rec'd by registrar) Huntington Williams MD (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/15 1948, at 6 AM

21. I certify that death occurred on the date above stated, that I attended deceased from April 1 1948 to April 14 1948, and that I last saw him alive on APRIL 14 1948.

Immediate cause of death	Duration
Myocardial Degeneration	4 days
Due to Arteriosclerosis	20 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?

(e) Means of injury

23. Signature Arthur J Davies.

Address 800 W 33rd St Date signed 4-15-48 M D

VS 150

X

G62315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

G62315

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 12-7

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs. mos. or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days) 4 Mo.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 215 W. 27th Street (If rural give location)

(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Mizelle D. Knight

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	

6 (b) Name of husband or wife Edgar Knight

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Nov. 20, 1895

8. AGE: Years	Months	Days	If less than one day hr.	min.
52	4	25		

9. Birthplace Florida (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name Frederick M. Douglas

13. Birthplace Georgia

MOTHER 14. Maiden Name Sarah Mizelle

15. Birthplace Florida

16 (a) Informant Mrs. Clarissa M. Knight

(b) Address 215 W 27th St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof April 16 1948 (month) (day) (year)

(c) Cemetery or crematory Dibble

Location Lake Butler, Florida

18 (a) Funeral director Putnam Dorsey

(b) Address 2224 N. Charles St.

19 (a) APR 16 1948 (Date rec'd by Local Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1948 at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 13 1948 to April 15 1948 and that I last saw her alive on April 15 1948.

Immediate cause of death: Cerebral Hemorrhage

Due to post operative thrombie

Due to

Other Conditions Tic Doulereaux

(Include pregnancy within 3 months of death)

Date of operation 4-14-48

Major findings of operation: Section of Sensory Root of 5th Nerve

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature W. M. H. M. D.

Address Date signed 4/15/48

X

G62316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G62316

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1714 Prestman St
(c) Hospital or institution: L
15.2
(d) Length of stay in hospital or inst. (yrs., mos., or days) L
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 Prestman St (If rural give location)
(e) If foreign born, how long in U. S. A.? ——— years

3 (a) FULL NAME Catherine Joyce

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fem.	Col	Widow

6 (b) Name of husband or wife: Moses Joyce
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 15 1882

8. AGE: Years	Months	Days	If less than one day
66	1	27	hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual Occupation: Domestic
11. Industry or business: L

FATHER
12. Name: John Anderson
13. Birthplace: Md.

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Md.

16 (a) Informant: Sarah Dent
(b) Address: 1714 Prestman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/48 (month) (day) (year)
(c) Cemetery or crematory: St Peters
Location: Md

18 (a) Funeral director: Isaac S. Nelson
(b) Address: 1303 Prestman St

19 (a) 4/16/1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1948, at 9 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-13-1948, to 4-14-1948, and that I last saw her alive on 4-13-1948.

Immediate cause of death: Acute Coronary Occlusion — Duration: 2 days
Due to: Myocarditis — Duration: Unknown
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations: L
Of autopsy: L

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: C. Mansell Lawrence, M.D.
Address: 1033 W Lanvale St Date signed 4/16/48

VS 8

X

G62317

G62317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195c

Registered No. _____

Typing or writing in PERMANENT, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland 340 - 11-4

(b) Street address

(c) Hospital or institution: Carmel St

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 340 (If r... Carmel St

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Ella Thornton THORNTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 19 1870

8. AGE: Years 77 | Months 6 | Days 4 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business ?

FATHER 12. Name M'd.

FATHER 13. Birthplace ?

MOTHER 14. Maiden Name "

MOTHER 15. Birthplace Md.

16 (a) Informant Chas. J. Thornton

(b) Address 386 - Carmel St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/48 (month) (day) (year)

(c) Cemetery or crematory Prot. Calvary

Location

18 (a) Funeral director J. Albert Fillm

(b) Address

APR 16 1948 (b) Huntington Williams

(Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 19 48 M

21. I certify that death occurred on the date above stated, that I attended deceased from April 14 1948 to 3:30 A.M. April 14 1948.

and that I last saw h... alive on April 14 1948.

Immediate cause of death Organic Heart Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which) While at work?

(e) Means of injury

23. Signature J. Garland Churchill

Address 1534 Druid Hill Ave. Date signed April 16 -

V2 180

G62318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8-B

Registered No. G62318

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1155 Hollins St.
(c) Hospital or institution: 18-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1155 Hollins St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph F. Cross

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 215-05-4585

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 9, 1898

8. AGE: Years	Months	Days	If less than one day
49	7	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Edward Cross
13. Birthplace New York

MOTHER
14. Maiden Name Margaret McKewen
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Nelson J. Connolly
(b) Address 64 S. Carrollton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/48. (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Joseph H. Poll
(b) Address 1201 W. Fayette St.

Apr 16 1948 (b) (registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1948 at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to 4-14-48 19..; and that I last saw him alive on 4-14-48 19..

Immediate cause of death Acute Hemoplegia

Due to Cerebral Thrombosis

Due to Chronic Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2-3 yr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. V. Langle
Address 642 W. Lan. Blvd. Date signed 4-16-48. M.D.

V S 150

R. V. Langle X

G62319

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46

G62319
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1530 N Payson St
(c) Hospital or institution: 15-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1530 N Payson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Cohen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced	6 (b) Name of husband or wife	6 (c) If alive, give age
male	White	married	Ida	years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day: hr	min
63				

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name unknown
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Ida Cohen
(b) Address 1530 No Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-16-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men
Location Windsor Mill Road

18 (a) Funeral director Jack Rewers Inc
(b) Address 2100 Eutaw Place

APR 16 1948 (Date rec'd by registrar)
Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-15- 1948, at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1947 to 15 April 1948, and that I last saw h(im) alive on 13 April 1948.

Immediate cause of death: Pleural Effusion — Duration: 2 wks

Due to Carcinoma of Stomach with Metastases.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None Performed

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Samuel Weisman M.D.
Address 3900 Dorchester Rd Date signed 16 April 48

G62320 Valentini

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

G62320 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3400 Oakenshaw Place

(c) Hospital or institution: 12-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3400 Oakenshaw Place (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Vincent A. Valentini

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Married

6 (b) Name of husband or wife Geneva Crane

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/1/1895

8. AGE: Years	Months	Days	If less than one day: hr.	min.
52	5	14		

9. Birthplace Baltimore (Town, county and state)

10. Usual Occupation Musical composer

11. Industry or business

FATHER 12. Name John J. Valentini

13. Birthplace Baltimore

MOTHER 14. Maiden Name Josephine Barth

15. Birthplace Baltimore

16 (a) Informant Mrs. Rena Gore

(b) Address 3400 Oakenshaw Pl.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (Month) (day) (year) 4/17/48

(c) Cemetery or crematory Druid Ridge

Location Park Ridge Rd.

18 (a) Funeral director John D. Baker

(b) Address 1318 Leighton Ave.

APR 16 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1948 at 12:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10 1948 to Apr. 15 1948 and that I last saw him alive on Apr. 15 1948.

Immediate cause of death

Carcinoma of lung

Due to ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature Jack L. Valentine M.D.

Address 1732 Broadway Date signed Apr. 15/48

VS 150

662321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 662321

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1108 Mosher St
(c) Hospital or institution: 16-1
(d) Length of stay in hospital or inst. (yrs., mos., or days).
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 Mosher (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W Braxton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	✓

6 (b) Name of husband or wife Mattie S Braxton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 9, 1874

8. AGE: Years	Months	Days	If less than one day
72 74	4	5	hr. min.

9. Birthplace Alexandria Va (Town, county, and state)
10. Usual Occupation Transfer
11. Industry or business Furniture

FATHER
12. Name Wesley Braxton
13. Birthplace Alexandria, Va

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs Mattie S. Braxton
(b) Address 1108 Mosher St

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 4-17-48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem Pk
Location Balto Co Md
18 (a) Funeral director Holland Funeral Home
(b) Address 1631 Druid Hill Ave

APR 16 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16/48 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/9/48 to 4/16/48 and that I last saw him alive on 4/16/48.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Paralysis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ellen R Wells M. D.
Address 2 Eyden Street Date signed 4/16/48

VS 150

G62322

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X G62322 Registered No.

1090

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: WEST BALTIMORE GENERAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County ANNE ARUNDEL
(c) City or town POINT PLEASANT (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ARTHUR F. BAUSTIAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of ~~husband or~~ wife ELFLEDA (DAY) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT 6 1891

8. AGE: Years	Months	Days	If less than one day
56	6	9	hr. min.

9. Birthplace PENNA (Town, county, and state)
10. Usual Occupation LINOTYPE OPERATOR
11. Industry or business BALTO LINOTYPE Co

FATHER
12. Name HENRY A. BAUSTIAN
13. Birthplace PENNA

MOTHER
14. Maiden Name ANNA
15. Birthplace PENNA

16 (a) Informant MRS ARTHUR F BAUSTIAN
(b) Address BOX 208 BROOKLYN-25 MD
17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof APRIL 1948 (month) (day) (year)
(c) Cemetery or crematory
Location YORK, PENNA.
18 (a) Funeral director Harry A Wilhelm
(b) Address 4101 Edmondson Ave
19 (a) 4 1948 (b) Registrar Wellington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-15 1948 at 5:10 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 4-13 1948 to 4-15 1948 and that I last saw h/her alive on 4-15 1948.

Immediate cause of death: Coronary thrombosis

Due to Coronary Sclerosis

Due to Cirrhosis Liver

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Duration

Date of operation

Major findings of operations:

Post-mortem examination

of autopsy: Chronic Hobnail Cirrhosis of Liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W. H. Bruneman M.D.
Address 1211 Park Ave. Baltimore Md. Date signed 4-15 48

VS 150

G62323

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G62323 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1743 E.Federal St.
(c) Hospital or institution: 8-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1743 E.Federal St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma E.Wenzel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife John 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct.30,1861

8. AGE: Years	Months	Days	If less than one day
86	5	16	hr. min.

9. Birthplace Baltimore (Town, county and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Francis Fulda
13. Birthplace Germany

MOTHER
14. Maiden Name Linck
15. Birthplace Baltimore

16 (a) Informant Mrs.Howard Hanson
(b) Address 1743 E.Federal St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 Broadway.

APR 16 1948 (b) (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1948, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1948 to April 5 1948, and that I last saw h alive on April 1 1948.

Immediate cause of death — Duration

E Renal Failure — 2 days
Due to Chronic Hypertension — 2 yrs
Due to
Other Conditions Senile Debility — 2 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Date signed 4/5/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

662324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓94a

662324 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24-4
(c) Hospital or institution: Saint Boltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) do
(e) Length of stay in Baltimore (yrs., mos., or days)

2 USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name)
(d) Street No. 1706 Williams Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Wengert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Carrie C. Boston

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) II/26/I890

8. AGE: Years 57 | Months 4 | Days I9 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Die Setter

11. Industry or business Nat. Enameling & Stpg. Co.

FATHER
12. Name Frederick Wengert
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Germany

16 (a) Informant Family
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/48 (month, day, year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director Thos. L. McCauley
(b) Address 130 East Fort Avenue
Huntington Williams, Mgr.
APR 16 1948 (Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15, 1948 at 1058 M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis

Due to

Other Conditions
(Include pregnancy within three months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place?
(d) Means of injury

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 4-15-48

VS 151

062325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 12R

Registered No. 062325

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 21-4
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city limits give township)
(d) Street No. 163 Fauntleroy Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME Jean Huffman (Nee McSHEEHY)

3 (b) If veteran, name war —

3 (c) Social Security Account No. 015-01-8508

4. Sex Female

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife WILSON K. HUFFMAN

6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) 7-22-13

8. AGE: Years 34 | Months 9 | Days 23 | If less than one day — hr. — min.

9. Birthplace Mass. (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name Morgan O. Sheehy
13. Birthplace Mass.

MOTHER
14. Maiden Name Margaret A. KASTAMA
15. Birthplace BROOKLYN N.Y.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (b) Date thereof APRIL 19, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ST. PATRICKS
Location WHITINSVILLE MASS

18 (a) Funeral director Walter Brooke Bradley
(b) Address 1922 W. North avenue

APR 16 1948 (b) Huntington Williamsville
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-15-48 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-10-48 to 4-15-48 and that I last saw her alive on 4-15-48

Immediate cause of death Resp. failure

Due to ? meningitis

Due to ? TBC

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Gusack, M.D.
Address J.H.H. Date signed 4-15 '48

Hal 2. SG62326 X Wall (SG2326) 340632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Calvert
(c) City or town Port Republic (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Hall
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-14-95

8. AGE: Years	Months	Days	If less than one day
52 years	11	1	hr. min

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Edward Hall
13. Birthplace Md

MOTHER
14. Maiden Name Martha Dorsey
15. Birthplace JOHNS HOPKINS HOSPITAL ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 17, 1948 (month) (day) (year)
(c) Cemetery or crematory Browns
Location Calvert County, Md.
18 (a) Funeral director F. E. Sewell
(b) Address Prince Frederick, Md.
19 (a) APR 16 1948 (b) Name of city or registrar Huntington W. Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-15-1948 at 5:45 a M

21. I certify that death occurred on the date above stated, that I attended deceased from 3-3-1948 to 4-15-1948 and that I last saw h[illegible] alive on 4-15-1948.

Immediate cause of death	Duration
Shock	8 hrs
Due to Operative procedure & peritonitis	48 hrs
Due to Carcinoma of stomach	14 yrs
Other Conditions Extensive metastases	

(Include pregnancy within 3 months of death)

Date of operation 4/13/48
Major findings of operation: Ca of stomach & extension to liver
Date of autopsy: same peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton Edgerton
Address Johns Hopkins Hosp Date signed 4/16/48

VS 153

G62327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

G62327
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton Road
(c) Hospital or institution: Ashburton Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 816 N. 34th Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Ida Mae Schneider

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Edward F. Schneider
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2 1920
8. AGE: Years 47 | Months 10 | Days 17 | If less than one day: hr. min
9. Birthplace: Baltimore, Maryland (town, county, and state)
10. Usual Occupation: At Home
11. Industry or business

FATHER
12. Name: James M. Spitz
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Irene M. Stansbury
15. Birthplace: Maryland

16 (a) Informant: Edward F. Schneider
(b) Address: 816 N. 34th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: April 17-1948 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville Maryland

18 (a) Funeral director: Burgee Funeral Home
(b) Address: 3631 Falls Road
(c) Interment or Cremation, Md.

19 Date received by registrar: APR 16 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1948, at 8:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to April 17 1948 and that I last saw her alive on April 12 1948.

Immediate cause of death: Staphylococcus & Esch. Coli Infection of Kidneys
Due to: Hypernephroma of left kidney, metastasis to Pineal gland & brain
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Duration

Date of operation Jan 1946
Major findings of operation: Hypernephroma of left kidney
of autopsy? No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence No at M
(c) Where did injury occur? No (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury
23. Signature: H. G. Jones M.D.
Address 2815 E. Lanvale Date signed April 15 1948

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G62328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121a

G62328

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2310 Mayfield Avenue

(c) Hospital or institution: 8.1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2310 Mayfield Avenue (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Clarence P. Burton

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-14-6947A

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Maude B. Burton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15-1883

8. AGE: Years 64 | Months 7 | Days 1 | If less than one day: hr. min.

9. Birthplace: Burtonville, Maryland (Town, county, and state)

10. Usual Occupation: Machinist

11. Industry or business

FATHER

12. Name: Jackson Burton

13. Birthplace: Maryland

MOTHER

14. Maiden Name: Margret Price

15. Birthplace: Maryland

16 (a) Informant: Mrs. Maude B. Burton

(b) Address: 2310 Mayfield Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 19-1948 (month) (day) (year)

(c) Cemetery or crematory: New Cathedral

Location: Baltimore, Maryland

18 (a) Funeral director: Burgee Funeral Home

(b) Address: 3691 Falls Road (Number and street or R.F.D. number, city or town)

19 (a) (Date rec'd by registrar) Registrar

APR 16, 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1948, at 4:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 1 19 48 to April 16 19 48 and that I last saw him alive on Apr. 10, 19 48.

Immediate cause of death

Hypertension Cardiovascular Renal Disease.

Due to

Due to

Other Conditions Cerebral hemorrhage.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature H. P. Friedman

Address 1319 Light St. Date signed 4/16/48 M D

G62329

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G62329 Registered No. 104

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Avenue
(c) Hospital or institution: Ardleigh Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3507 Chestnut Avenue (If rural, give location)
(e) Citizen of foreign country? No Yes or No
If yes, name country

3 (a) FULL NAME Theodore T. A. Shue

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Fannie Steele Shue
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Nov. 13-1870

8. AGE: Years 77 | Months 5 | Days 2 | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, or state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER 12. Name Ephriam A. Shue
13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Mary Sterner
15. Birthplace Pennsylvania

16 (a) Informant Granville D. Shue
(b) Address Green Pasture Lane Towson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 19-1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date rec'd by registrar) APR 20 (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15- 1948, at 12 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 0 April 1948, to 15 April 1948, and that I last saw h/m alive on 14 April 1948.

Immediate cause of death ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE — LOBAR PNEUMONIA RIGHT — Duration
Due to UREMIA. (TERMINAL)
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which) While at work?
(e) Means of injury

23. Signature W. Kennedy Waller, M.D.
Address 517 Cathedral St Date signed 16 April 48

G62330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Agroi ✓ G62330 Registered No. 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 114 N. East Ave
(c) Hospital or institution: 26-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 N. East Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sophie M. Agroi

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-0738

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Agatino Agroi
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) August-15-1900

8. AGE: Years	Months	Days	If less than one day: hr.	min.
47	8	30		

9. Birthplace Italy (City, county, and state)

10. Usual Occupation
11. Industry or business Kelly's Brothers

MOTHER / FATHER
12. Name Filio Saglivia
13. Birthplace Italy
14. Maiden Name Maria Lo Presti
15. Birthplace Italy

16 (a) Informant Agatino Agroi
(b) Address 114 N. East Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Frederick Ave

18 (a) Funeral director John C. Miller Inc
(b) Address 2 [illegible] Oliver St

4-16-1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1948, at 4:20 P.M.

21. I certify that death occurred on the date above stated: that I attended deceased from Oct 1 1947 to April 14 1948 and that I last saw her alive on April 14 1948:

Immediate cause of death Cardiac Failure — Duration

Due to Hemorrhage — Repeated

Due to Carcinoma Uterus Extension

Other Conditions Recto Vag Fistula Vesico Vag Fistula.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Martin J. Lamantia M.D.
Address 333 S. East Ave Date signed 4/16/48

VS 150

X

BALTIMORE CITY HEALTH DEPARTMENT ✓ 662331 Registered No.

CERTIFICATE OF DEATH 59a

662331 B.M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 21-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 Sterrett St. ? (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Gardner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1866

8. AGE: Years	Months	Days	If less than one day
82 8 ?			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Metz
13. Birthplace France

MOTHER
14. Maiden Name Ellen ?
15. Birthplace Maryland

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/16/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart.
Location Seminary Rd. Rockville Pike

18 (a) Funeral director D. J. Caley & Sons
(b) Address 1218 Light St.

19 (a) [illegible] by registrar Thurlington Williams, M.D. registrar

APR 16 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-13-48 19 , at 7:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15- 19 29 to 4-13 19 48 and that I last saw her alive on 4-13- 19 48

Immediate cause of death: Cardiac failure.
Due to: Enteroptosis. Generalized
Due to:
Other Conditions: Rheumatoid arthritis
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Vanhuss Jr. M.D.
Address Balto City Hosp. Date signed 4/16 1948

97

062332

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 062332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — EUTAW
(b) Street address 1913 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 Eutaw Place (If rural give location)
(e) Citizen of foreign country EUTAW (Yes or No)
If yes, name country

3 (a) FULL NAME J Alban Smoot

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex Male — 5. Color or race White — 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Rachel A Smoot

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. July 1862

8. AGE: Years 85 | Months 86 | Days 9 | If less than one day hr. min.

9. Birthplace Charles Co Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Lemuel Smoot
13. Birthplace Md

MOTHER — 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs Schwarzkopf
(b) Address 4190 Hall Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Milton Cox Sons
(b) Address 1219 Park Ave

19 APR 17 1948 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1948, at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 12 1948, to April 17 1948, and that I last saw him alive on April 12 1948.

Immediate cause of death: Chronic hypocardiatis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within three months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H H Guttenman

Address 2314 Reisterstown Rd Date signed 4/16/48 M. D.

VS (5)

X

G62333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G62333 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Un Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 203 Penal St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Willie Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. april 6, 1889

8. AGE: Years 59 | Months - | Days 8 | If less than one day hr min

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name major Hill

13. Birthplace S. C.

MOTHER 14. Maiden Name mary Owens

15. Birthplace S. C.

16 (a) Informant Carry Burden

(b) Address 1804 Lorman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-18-48 (month) (day) (year)

(c) Cemetery or crematory Greenville S.C.

Location S.C.

18 (a) Funeral director George B. Kelson

(b) Address 1303 Presstman St

19 Filed (Date received by registrar) (b) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1948, at 7 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 24 1948, to 4-15 1948, and that I last saw him alive on 4-15 1948.

Immediate cause of death Cardio Resp failure — Duration 2 mo.

Due to (a) Pulmonary Metastases

Due to (b) Adeno carcinoma originating from GI tract / most likely colon

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Confirmed Primary Metastases

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify one of these)

(e) Means of injury

23. Signature B & L Lamman M. D.

Address 1 Mount Hope Pl. Balto. Date signed 4-16-48

VS 150

X

G62334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55B

Registered No. 68334

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Windsor Hills Forest Park Cem
(c) Hospital or institution:
Kernan Hospital, Baltimore 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8½ mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 N. Gilmore
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Montgomery Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	negro	single

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 6-16-34

8. AGE: Years	Months	Days	If less than one day
13	10	—	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation School boy
11. Industry or business

FATHER
12. Name Clarence Johnson
13. Birthplace

MOTHER
14. Maiden Name Mary Montgomery
15. Birthplace

16 (a) Informant Mary Montgomery (mother)
(b) Address 1613 N. Gilmore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn.
Location Md.

18 (a) Funeral director George G. Kelson
(b) Address 1303 Pennsylvania Ave

19 APR 17 1948 (Date rec'd by Registrar) (b) Huntington Woodlawn Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1948, at 10:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 22 1947, to April 15 1948, and that I last saw him alive on 4-15 1948.

Immediate cause of death: Cardiac failure (terminal) — Duration: 8½ mos.

Due to: Osteogenic sarcoma, left tibia with generalized metastasis

Due to

Other Conditions: Generalized edema and cachexia.
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert B Pearce M. D.
Address Kernan Hospital Date signed 4-15-48

V S 190

X

662335

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

517

Registered No. 662335

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2123 E Hoffman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** DANIEL MAURICE BLACKWELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Viola Blackwell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1900

8. **AGE:** Years 47 | Months 7 | Days 17 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Daniel Blackwell

13. Birthplace Md

MOTHER 14. Maiden Name Sarah Jordon

15. Birthplace Md

16 (a) Informant Lula Simms

(b) Address 2123 Etting St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-20-48 (month) (day) (year)

(c) Cemetery or crematory Woodland Park Cem

Location Md

18 (a) Funeral director George E. Nelson

(b) Address 1303 Pennsylvania Ave

19 APR 17 1948 (Date rec'd by Registrar) Burial Permit Issued

MEDICAL CERTIFICATION

20. **DATE OF DEATH** April 16 1948, at 4:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 12 1948, to April 16 1948, and that I last saw him alive on April 16 1948.

Immediate cause of death: Cerebral anemia — Duration

Due to: Respiratory arrest

Due to: Tonsilectomy ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4-15-48

Major findings of operation: Carcinoma

of autopsy: Pending

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?) (Specify type of place)
(e) Means of injury

23. **Signature** W. Clifford Scarborough M. D.

Address University Hosp Date signed 4-16-48

VS-15

X

662336 SOBOTKA

BC - 48-08486 BALTIMORE CITY HEALTH DEPARTMENT 159 Registered No. 662336

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Mercy Hosp. 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside corporate limits, write RURAL and give town)
(d) Street No. 176 N Decker Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby John Sobotka

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-14-48

8. AGE: Years | Months | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Adam Sobotka
13. Birthplace Balto

MOTHER 14. Maiden Name Margaret Jaskulski
15. Birthplace Balto.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Balto. County

18 (a) Funeral director John F. Weber
(b) Address 404 S. Chester St

19 APR 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 16 1948 at 9 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-14 1948 to 4-16 1948 and that I last saw h/ alive on 4-16 1948

Immediate cause of death circulatory Collapse.
Due to Prematurity.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature J. F. Ellsperger M.D.
Address Mercy Hosp. Date signed 8-17-48

X

VS 150

662337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. 662337

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3901 Roland Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3901 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas G. Reynolds

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-6580

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Catherine Reynolds
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Feb 7, 1902

8. AGE: Years	Months	Days	If less than one day
46	2	8	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Drug Clerk
11. Industry or business Retail Store

FATHER 12. Name	James J. Reynolds
13. Birthplace	Maryland
MOTHER 14. Maiden Name	Margaret Banahan
15. Birthplace	Maryland

16 (a) Informant Catherine Reynolds
(b) Address 3901 Roland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 19/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director Cantin E. Donovan
(b) Address 3638 Roland Ave.

19 (a) Date received by registrar (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15, 1948, at 6 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/15 1948 to 4/15 1948, and that I last saw him alive on 4/15 1948.

Immediate cause of death: Acute cardiac dilatation — Duration: hrs.

Due to Cardio-renal vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. McDaniel Jr. M.D.
Address 1800 N. Charles St Date signed 4/16/48

VS 150

X

62338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. 62338

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1223 Union Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1223 Union Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward E. Mason.

3 (b) If veteran, name war

3 (c) Social Security Account No. 215 01 5837

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Leola D. Mason.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1875

8. AGE: Years	Months	Days	If less than one day
72	9	6	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Steel Worker

FATHER
12. Name John Mason.
13 Birthplace Maryland.

MOTHER
14. Maiden Name Unknown.
15 Birthplace Unknown.

16 (a) Informant Edward L. Mason.
(b) Address 1223 Union Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 17/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn.
Location

18 (a) Funeral director Austin E. Donovan.
(b) Address 3638 Roland Ave.

19 (a) APR 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14, 1948 at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-10 19 48 to 4-14 19 48 and that I last saw h.i.m alive on 4-14 19 48

Immediate cause of death Gastro Intestinal Polyneuritis Progressive — Duration 4 Days.

Due to

Due to

Other Conditions Hypertension C V D (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Laurence J. Linamboo M.D.
Address 371 Fallsway Date signed 4-14 48

VS 150

870

Spec.—1-50—M. & T.—500 Blks.

C62339 C62339

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 94B

1-PLACE OF DEATH 1806 Mosher

CITY OF BALTIMORE: (No. 1806 Mosher ST., WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter T. Lane

(a) RESIDENCE NO. 1806 MOSHER ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of FLORA FRANKLIN LANE

6 DATE OF BIRTH (month, day, and year) APR. 25, 1874

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work PAPER HANGER

(b) General nature of industry, business, or establishment in which employed (or employer) SELF

(c) Name of employer SELF

9 BIRTHPLACE (city or town) (State or country) ATLANTA, GA.

PARENTS

10 NAME OF FATHER JOSEPH LANE

11 BIRTHPLACE OF FATHER (city or town) (State or country) GA

12 MAIDEN NAME OF MOTHER FANNIE HURD

13 BIRTHPLACE OF MOTHER (city or town) (State or country) GA

14 Informant MRS. WM. A. REED

(Address) 4502 WENTWORTH RD. 2

15 APR 17 1948 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1948

17 I HEREBY CERTIFY, That I attended deceased from April 15th 1948 to April 15 1948 that I last saw him alive on April 5th 1948, and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

complicated with Angina Pectoris

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Terminal Bronchitis

(duration) 4h yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Natural

(Signed) H. D. Hammer, M. D.

of 15 1948 (Address) 1929 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL WOODLAWN

DATE OF BURIAL 4/17 1948

20 UNDERTAKER WM. J. TICKNER & SONS

ADDRESS 2016 W. North Ave. Baltimore, Md.

IF VERY IMPORTANT—See instructions on back of certificate.

G62340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. G62340

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5505 HIGHGATE DR.
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 5505 HIGHGATE RD. (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country

3 (a) FULL NAME EDITH MARION LEE BRYAN

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced WIDOWED

6 (b) Name of husband or wife CLAUDE A BRYAN

6 (c) If alive, give age years

7 Birth date of deceased mo., day, yr. JULY 23, 1870

8 AGE: Years 57 | Months 8 | Days 23 | If less than one day hr. min.

9 Birthplace CENTREVILLE, MD. (Town, county, and state)

10. Usual Occupation Dom't HOUSEKEEPER

11. Industry or business STRATHAM HOTEL

FATHER 12. Name JAMES R. MORGAN

13. Birthplace MD.

MOTHER 14. Maiden Name ELLA P. STARTT

15. Birthplace MD.

16 (a) Informant MR. STANLEY B BRYAN

(b) Address 5505 HIGHGATE DR. (15)

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-19-48 (month, day, yr.)

(c) Cemetery or crematory WOODLAWN

Location BALTO CO., MD.

18 (a) Funeral director WM. T. TICHNER SONS

(b) Address BALTO, MD.

19 APR 17 1948 (Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16 1948, at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 15 1948, to Apr 16 1948, and that I last saw h alive, on Apr 16 1948.

Immediate cause of death (a) Uremia — Duration: Many years

Due to (b) Cerebral Arteriosclerosis — Duration: 3 yrs

Due to (c)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or county) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which)

(e) Means of injury

(f) Signature

Address Date signed 4/17/48

VS 150

662341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9=D

Registered No. 662341

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians please write the causes of death clearly and legibly

1. PLACE OF DEATH
(a) Baltimore City Maryland
b. Street address 817 WOODWARD ST
c. Hospital or institution
d. Length of stay in hospital or instn. yrs. mos. or days
e. Length of stay in Baltimore yrs. mos. or days

2. USUAL RESIDENCE OF DECEASED
a. State MD
b. County
c. City or town BALTIMORE
d. Street No. 817 WOODWARD ST
e. Custom of foreign country Yes or No
If yes name country

3. a. FULL NAME WILLIAM J KIRBY
b. If veterans, name war
Social Security Number No. 212-14-7366

4. Sex MALE
5. Color or race White
6. a. Single, married, widowed or divorced WIDOWED
b. If married, widowed or divorced, name of husband or wife LORETTA
If widow, give age
7. Birth date of deceased Nov 24 - 18[illegible]
8. AGE Years Months Days If under 1 day, hours or minutes
67 Y
9. Birthplace BALTIMORE MD
10. Usual Occupation RETIRED
11. Industry or business

PARENTS
12. Name of father JOSEPH KIRBY
13. Birthplace BALTO MD
14. Maiden name of mother MARY ?
Birthplace BALTO MD

15. a. Informant MARY BURKHEAD
b. Address 219 SCOTT ST

16. a. BURIED 4/19/48
b. Cemetery or crematory HOLY CROSS H A CO
Location

17. a. Undertaker Bernard C Hinkle
b. Address 421 E Fayette St
c. Date received Baltimore Md

MEDICAL CERTIFICATION

18. DATE OF DEATH APRIL 16 1948 ~7 25 P M

19. I certify that death occurred on the date above stated that I attended deceased from Aug 10 1947 to April 16 1948 and that I last saw h[illegible] on April 16 1948

Cerebral Hemorrhage, Left
Hypertensive Cardiovascular Disease

Duration 3 days
1

PHYSICIAN

Date of operation
Major findings of operation

20. Was operation performed for any of the following
a. Accident, suicide or homicide
b. Date of occurrence
c. Time
d. Place where occurred
e. Did injury occur in or about home, factory, street or public place

Manner of injury

John P Welsh Jr
(Signature) Welsh Clinic
(Address) 1417 Eutaw Pl

662342

662342

BALTIMORE CITY HEALTH DEPARTMENT

Registered No.

CERTIFICATE OF DEATH

107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined for correct spelling and legibility. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH

(a) Baltimore City, Maryland

(b) Street address [illegible] Ave & Madison St

(c) Hospital or institution Maryland General Hospital

(d) Length of stay in hospital or state (yrs., mos. or days) 1 day

(e) Length of stay in Baltimore (yrs., mos. or days) 2 days

2. USUAL RESIDENCE OF DECEASED

a. State Md. b. County Talbot Co.

c. City or town [illegible]

d. Street No. [illegible]

e. Citizen of foreign country? (Yes or No)

If yes, name country

2 (a). FULL NAME Albert Franck, Jr.

3 (b). If veteran, name war

3 (c). Social Security Account No.

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced Single

6. (b). Name of husband or wife

6. (c). If widow, give age

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1905

8. AGE Years 21 Months Days If under one day, hours or minutes

9. Birthplace Baltimore, Md.

(Town, county and state)

10. Usual Occupation Artist

11. Industry or business

FATHER

12. Name Albert Franck

13. Birthplace Bavaria, Germany

MOTHER

14. Maiden Name Mabel Wooster

15. Birthplace Virginia

16. a. Informant [illegible]

b. Address [illegible]

17. a. Burial, cremation, or removal

b. Date thereof 4 20 48

(mo., day, yr.)

c. Cemetery or crematory [illegible]

Location [illegible]

18. (a) Funeral director [illegible]

(b) Address [illegible]

19. (a) APR 17 1948 Huntington Williams, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1948 at 4:45 P.M.

21. I certify that death occurred on the date above stated, that I attended the deceased from April 9 1948 to April 16 1948 and that I last saw the deceased alive on April 16 1948

Immediate cause of death Cardiac arrest

Due to Pneumonia

Due to

Due to

Other conditions

Duration

9 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

Date of operation

Major findings of operation

22. If death was due to external causes, fill in the following:

a. Accident, suicide or homicide

b. Date of occurrence

c. Where did injury occur? (City or town, county, State)

d. Did injury occur in or about home, on farm, industrial place, or public place? (Specify type of place)

e. Means of injury

23. Signature C. Jones Mont

Address Md. Gen. Hosp. Date signed 4/16/48

vs-8c

062343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186B

Registered No. 062343

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md.
(b) County
(c) City or town Baltimore
(If outside city or town limits, write R.F.D. and give town)
(d) Street No. 121 N. Montford avenue
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Antonio TARESCO

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-05-1843

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose Taresco

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Feb. 13, 1894

8. AGE: Years: 54 | Months: 2 | Days: 3 | If less than one day: hr. ____ min. ____

9. Birthplace: Teramo Italy
(Town, county, and state)

10. Usual Occupation: Pipelayer

11. Industry or business

FATHER
12. Name: Vincenzo Taresco
13. Birthplace: Italy

MOTHER
14. Maiden Name: Carmela
15. Birthplace: Italy

16 (a) Informant: Rose Taresco (Wife)
(b) Address: 121 N. Montford ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4-19-48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd. Balto. Md.

18 (a) Funeral director: Frank Della Rocca
(b) Address: 52 N. Monroe St.

19 (a) APR 17 1948 (Date rec'd by registrar) (b) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16, 1948, at 20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ or suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Crushed chest.
Ruptured heart.
Fractured pelvis.
Ruptured liver, spleen, and Kidney

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-16-48 26-03 M.
(b) Where did injury occur? Maryland & Kentucky Avenues
(c) Did injury occur at home, on farm, industrial place or in public place? Public (Specify home, farm, industrial place or public place) (Working for Contractor) (While at work?) Yes
(d) Means of injury Cave-in sewer

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 4/16/48

VS 181

X

162344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 162344

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3702 Ednor Rd.
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3702 Ednor Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH M. LITTLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	divorced

6 (b) Name of husband or wife Alexander J. Little

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11th, 1880

8. AGE: Years	Months	Days	If less than one day
68	1	5	hr. min.

9. Birthplace Cecil County, Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

MOTHER / FATHER

12. Name John Moore

13. Birthplace Unknown

14. Maiden Name Mary Unknown

15. Birthplace Unknown

16 (a) Informant Mrs. Irving Greif

(b) Address 3702 Endor Rd.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 4/19/48 (month) (day) (year)

(c) Cemetery or crematory Angel Hill

Location Havre de Grace

18 (a) Funeral director Lazarus Funeral Home

(b) Address 7401 Belair Rd.

19 (a) APR 7 1948 (Date received by registrar) (b) Tunstall Williams, M.D. Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH April 16th, 1948, at 12:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to 16 Apr 1948 and that I last saw her alive on 16 Apr 1948.

Immediate cause of death	Duration
Gastric Carcinoma	5 Mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 16 Dec 1947

Major findings of operation: Carcinoma of Stomach, metastatic to Liver

of autopsy X

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide?
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Z Bruce Hooper M.D.

Address 3504 Ellerslie Ave. Date signed 16 Apr 48

VS 150

X

662345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 662345

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1510 Bolton St
(c) Hospital or institution:

14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 Bolton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary P. B. Findlay

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1861

8. AGE: Years	Months	Days	If less than one day
86	10	?	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Findlay
13. Birthplace Hash. D. C.

MOTHER
14. Maiden Name Elizabeth H Boyd
15. Birthplace Balto Md

16 (a) Informant Mrs. M. Findlay French
(b) Address 3902 Canterbury Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 19 1948 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry M. Lenking Sons & Bro
(b) Address McCulloh & Richard Sts

19 (a) Date received by registrar 1948 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16th 1948, at 9a M

21. I certify that death occurred on the date above stated; that I attended deceased from March 16 1948, to April 16 1948, and that I last saw h[illegible] alive on Jan 16 1948.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Hypertensive Heart Disease	1 yrs
Due to [illegible] Illness	—
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. S. Ehrlich M. D.
Address 1510 Bolton St Date signed April 17 1948

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

662346

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 662346

The entries on this certificate should be carefully supplied. Information is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 331- N. Fulton ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 331- N. Fulton ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elisha Parker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	Col	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr Sept 10, 1876

8. AGE: Years (75) | Months 7 | Days 4 | If less than one day hr. min.

9. Birthplace ? (Town, county and state)

10. Usual Occupation unemployed
11. Industry or business ?

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Idamae Skates
(b) Address 331- N. Fulton ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/48 (month) (day) (year)
(c) Cemetery or crematory Location Mt Calvary A. Baltimore

18 (a) Funeral director A. Skelton & Son
(b) Address 918- Druid Hill Ave

19 (a) APR 17 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/14/48 19 at 4:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1/48 19 to 4/14/48 19 and that I last saw [illegible] alive on 4/13/48 19

Immediate cause of death Myocarditis — Duration unknown

Due to Hypertension

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Walter F Sasser
Address 401 N Edmondson Ave Date signed 4/14/48 M.D.

VS 150

5323

G62347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G62347

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert Sts

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Harford

(c) City or town Whiteford (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No) No

If yes, name country

3 (a) FULL NAME Robert Hopkins

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Mrs Robert Hopkins

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr 2/11/82

8. AGE: Years	Months	Days	If less than one day: hr	min
66	2	6		

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Quarry

11. Industry or business

FATHER

12. Name James Ramsey Hopkins

13. Birthplace Maryland

MOTHER

14. Maiden Name Henrietta Baughter

15. Birthplace Harford Co. Md.

16 (a) Informant Delmar Hopkins

(b) Address Delta, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/48 (month) (day) (year)

(c) Cemetery or crematory Slate Ridge

Location York Co. Pa

18 (a) Funeral director Hubert P Haikins

(b) Address Delta, Pa.

19 APR 17 1948 (Date rec'd by registrar) Territory of Northern Mariana, Mail (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1948, at 6:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/4 1948 to 4/17 1948, and that I last saw him alive on 4/17 1948

Immediate cause of death: Congestive heart failure

Due to: Hypertension arteriosclerotic heart disease

Due to:

Other Conditions: Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

2½ weeks

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)

(e) Means of injury

23. Signature John A. Drecker

Address Union Memorial Hosp. Date signed 4/21/48

VS 150

G62348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G62348 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 883 W Lombard St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Churchville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Bracks Page Bridge
(If rural give location)
(e) If foreign born, how long in U. S. A.) years

3 (a) FULL NAME Hannah a. Knight.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband ~~or wife~~: Robert F Knight
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1863

8. AGE: Years 84 | Months 0 | Days 25 | If less than one day: hr. 14 min.

9. Birthplace Harle-de-Grace Harford Co Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Hartlett
13. Birthplace Havre-de-Grace Md.

MOTHER
14. Maiden Name Elizabeth Wallace Fairey
15. Birthplace Fairey Town Penna

16 (a) Informant Mrs. Ruth Walters
(b) Address 921 S. Paca st Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 20 1948 (Month) (day) (year)
(c) Cemetery or crematory Angle Hill
Location Havre de Grace Md

18 (a) Funeral director Henry Fanning Sons
(b) Address Aberdeen Md

19 (a) [illegible] (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 - 1948, at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1948 to April 17 1948, and that I last saw h[illegible] alive on 4/14/48 19

Immediate cause of death
Hyp Cardiac
Due to Hyp Bronchopneumonia
Due to Senile Atrophy

Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter F Dorsey M.D.
Address 4017 Edmondson Ave Date signed 4/17/48

VS 3

X

G62349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

90 B

Registered No. G62349

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 649 W. Franklin St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. Md. (If outside city limits, write RURAL and give town)

(d) Street No. 649 W. Franklin St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Phyllis Scott.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Oye Scott.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Sumter S. Carolina (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Shapp English

13. Birthplace S. Carolina

MOTHER 14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Louisa Hadley Ribber

(b) Address 649 W. Franklin St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 4 14 48 (month) (day) (year)

(c) Cemetery or crematory Sumter S. Carolina

Location

18 (a) Funeral director Walter R. Briggs

(b) Address 1340 W. Hamilton St.

19 (a) APR 17 1948 (Date rec'd by registrar) (b) Burlington, North Carolina

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1948, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1948 to April 16 1948; and that I last saw him alive on April 14 1948.

Immediate cause of death: Pericarditis with hypertension

Duration
1

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature F. Ostergaard M. D.

Address 624 N. Broadway Date signed 4/17/48

VS 150

C62350

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1210

C62350 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 S. CAREY
(c) Hospital or institution: ✓ ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1000 S. CAREY ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA ZALEGERIS

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. None

4. Sex FEMALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced WIDOWED

6 (b) Name of husband or wife VINCENT

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 15 - 1875

8. AGE: Years 73 | Months 8 10 | Days 1 | If less than one day hr min

9. Birthplace Lithuania (Town, county, and state or foreign country)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant DAUGHTER VICTORIA

(b) Address 1000 S. CAREY ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-19-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road.

18 (a) Funeral director C. W. Zachariades

(b) Address 703 McHenry St.

19. APR 18 1948 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 16 1948 at 6.45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 22 JULY 1947 to 16 APR 1948 and that I last saw her alive on 15 APR 1948.

Immediate cause of death CARDIO-VASCULAR RENAL DISEASE — Duration 1 YR

Due to ARTERIOSCLEROSIS — Duration UNKNOWN

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: NO
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward F. Nolan M.D.

Address 682 WASHINGTON BLVD. Date signed 17 APR 48 M.D.

VS 150

BAO 0-30. MD

Dr F. M. adams

G62351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12/9 G62351

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 425 N. Wolfe St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 1 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 425 N. Wolfe st (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William Griggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. June 5 - 1879

8. AGE: Years 68 | Months 10 | Days 11 | If less than one day hr. min.

9. Birthplace Cumberland Co va (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER 12. Name William Griggs

FATHER 13. Birthplace Cumberland Co va

MOTHER 14. Maiden Name Eliza adkins

MOTHER 15. Birthplace Cumberland Co. Va

16 (a) Informant John Watkins

16 (b) Address 425 N. Wolfe St

17 (a) Burial (Burial, cremation, or removal)

17 (b) Date thereof April 19, 1948 (month) (day) (year)

17 (c) Cemetery or crematory Green Creek Cem

Location Cumberland Co. va

18 (a) Funeral director Elroy O. Wilson

18 (b) Address 1000 Brantly ave

APR 18 1948 (Date received by registrar)

(b) Certificate No. [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1948 at 5.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 1948 to April 16 1948 and that I last saw him alive on April 14 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration 4 Days

Due to Hypertensive Cardio Vascular Renal Disease ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature F. M. Adams

Address 1202 N. Carolina Date signed 4-17-48

VS 151

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G62352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √134a

G62352 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Broadway
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore yrs., mos., or days 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 819 N. Utah St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country Estonia

3 (a) FULL NAME Ruth B. Meyers
3 (b) If veteran, name war —
3 (c) Social Security Account No. 262-12-9064

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased mo., day, yr JAN. 23, 1910

8. AGE: Years	Months	Days	If less than one day
38	2	23	hr — min

9. Birthplace Charleston, W. Va. (Town, county and state)
10. Usual Occupation Laundry Clerk
11. Industry or business White Laundry

FATHER
12. Name Blair, Mr. Charles D.
13. Birthplace Marietta, Ohio

MOTHER
14. Maiden Name Sprague, Miss Lillian
15. Birthplace Marietta, Ohio

16 (a) Informant Ruth B. Meyers
(b) Address 819 N. Utah St.

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 4/19/48 (month) (day) (year)
(c) Cemetery or crematory CHARLESTON, W. Va.
Location

18 (a) Funeral director WM A. TICKNER & SONS
(b) Address BALTO. MD.
19 (a) APR 18 1948 (Date received by registrar) by Lillington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 15 1948 at 12PM
21. I certify that death occurred on the date above stated; that I attended deceased from MAR. 18, 1948 to Apr. 15 1948 and that I last saw her alive on Apr 15th 1948

Immediate cause of death Uremia — Duration 2 days
Due to Pericephritic abscess right — 15 days
Due to —
Other Conditions Non-functioning left kidney — 5 years
(Include pregnancy within 3 months of death)

Date of operation 3-25-48
Major findings of operation: Renal and ureteral calculi; duplex pelvis & ureter
of autopsy: Pericephritic abscess

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury
23. Signature R. L. Morrow M. D.
Address Church Home & Hosp. Date signed 4-15-48

VS 150

Please write PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

662353

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

662353

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 9a
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 2108½ Lake ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Esau~~ Katherine Gillespie

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: David Gillespie SR.

6 (c) If alive, give age: dead years

7. Birth date of deceased (mo., day, yr.): Feb 7, 1882

8. AGE: Years: 66 | Months: 2 | Days: 10 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: THOMAS E Hayes
13. Birthplace: Balto. Maryland

MOTHER
14. Maiden Name: Almira Tibbels
15. Birthplace: Balto. Maryland

16 (a) Informant: MR. David Gillespie Jr.
(b) Address: 1824 Clifton ST.

17 (a) Burial (Burial, cremation, or removal): (b) Date thereof: 4/20/48 (mo., day, yr.)
(c) Cemetery or crematory: Moreland Park
Location: Balto. Md.

18 (a) Funeral director: Wm L. Tucker & Sons
(b) Address: Balto. Md.

APR 18 1948
(Date received by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1948, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 8 1948 to April 17 1948, and that I last saw her alive on April 17 1948.

Immediate cause of death	Duration
Hypostatic pneumonia	2days.
Due to Cerebral lesion	1yr
Due to Pseudo Cushing's Syndrome	1yr
Other Conditions Diabetes Hypertension	1yr

(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town, County, State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(e) Means of injury:

(f) Signature: D. Otis Montgomery M.D.
Address: Mercy Hospital (Date signed April 17 1948)

VS 199

E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G62354 / 163H

Registered No. G62354

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dth
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 N. Washington St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George T. Settar

3 (b) If veteran, name war No

3 (c) Social Security Account No. 216-16-8322

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: MANDELLA SETTAR

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): APR. 7, 1884

8. AGE: Years: 64 | Months: | Days: 9 | If less than one day: hr. min.

9. Birthplace: PA
(Town, county, and state)

10. Usual Occupation: LATHER (RETIRED)

11. Industry or business: —

FATHER
12. Name: JOHN SETTAR
13. Birthplace:

MOTHER
14. Maiden Name: WILHELMINA FAILE
15. Birthplace:

16 (a) Informant: MRS. MANDELLA SETTAR
(b) Address: 1224 N. WASHINGTON

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/20/48 (month, day, year)
(c) Cemetery or crematory: BALTIMORE
Location: BALTO., MD.

18 (a) Funeral director: WM. J. TICHNER & SONS
(b) Address: BALTO. MD.

APR 18 1948 (Date rec'd by registrar)

Huntington for Indiana, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1948 at 4:45 PM

21. I certify that I took charge of the remains described above, held an Insp. Chg. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to illuminating gas

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-16-48 at 4:45 P.M.
(b) Where did injury occur? 1224 N. Washington St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury: How from gas burner in room

23. Signature: Howard J. Reese M.D.
Medical Examiner.
Date signed 4-17-48

VS 181

X

G62355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G62355 Registered No.

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14 S. Payson St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 14 S Payson St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Black

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 216-07-5966

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna V. Black
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 25, 1876

8. AGE: Years 72 | Months 2 | Days 22 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business:

FATHER
12. Name: Henry Black
13. Birthplace: Germany

MOTHER
14. Maiden Name: Pauline
15. Birthplace: Germany

16 (a) Informant: Anna V. Black
(b) Address: 1911 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-48 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Baltimore, Md.

18 (a) Funeral director: George E. Schwab
(b) Address: 201 Fredrick Avenue

19 APR 18 1948 (Date rec'd by registrar) Huntingtown, Maryland (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16, 1948 at 2:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 19 47 to April 16 19 48 and that I last saw him alive on April 16, 19 48.

Immediate cause of death
Coronary Thrombosis — Duration: 6 Months

Due to
Articular fibrulation

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Dane W. Hanna M.D.
Address 1945 W. Baltimore St. Date signed 4-16-48

VS 190

G62356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G62356
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 305 S Augusta Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 305 S. Augusta Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Atwell Thanton

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 213-10-0124

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife: None
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 11, 1891

8. AGE: Years	Months	Days	If less than one day: hr.	min.
56	9	5		

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Richard Thanton
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Martin
15. Birthplace Maryland

16 (a) Informant Mrs. Lydia Eberlein
(b) Address 305 S. Augusta Ave,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md

18 (a) Funeral director George F. Schmidt
(b) Address 2101 Frederick Ave.

19 (b) APR 18 1948 (Date rec'd by registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16, 1948, at 12:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-5 1928 to 4-16 1948 and that I last saw him alive on 4-16-1948.

Immediate cause of death	Duration
Acute Myocarditis	Sudden
Due to Diabetes Mellitus	15 years
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: —

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature J. Lloyd Johnson M. D.
Address Catonsville Date signed 4/17/48.

VS 150

G62357

GM. 118893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G62357

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 926 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nancy Grant

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 19 - 1903

8. AGE: Years	Months	Days	If less than one day hr.	min.
44				

9. Birthplace MD.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name David Grant
13. Birthplace MD.

MOTHER
14. Maiden Name Mary Stewart
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-22-48 (month) (day) (year)
(c) Cemetery or crematory Rose Hill Cemetery
Location Hagerstown, Md.

18 (a) Funeral director William H Downey
(b) Address 281 Frederick St Hagerstown Md

19 (a) (b)
(Signature of registrar) Registrar

APR 18 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 17 - 1948, 1030 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4 - 13 - 48 to 4 - 17 - 1948, and that I last saw her alive on 4 - 17 - 48.

Immediate cause of death	Duration
Congestive Heart Failure	3 weeks
Due to Hypertensive Cardiovascular Disease & Heart Stroke	6 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury
23. Signature Lawrence Lee Jr M D
Address Baltimore City Hospitals Date signed 4-17-48

X

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G62358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G62358 Registered No.

1. PLACE OF DEATH: West Balto General Hosp
(a) Baltimore City, Maryland
(b) Street address Rayner & Dukeland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3406 Cakfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ISRAEL BUCKNER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1873

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation
11. Industry or business Retired Merchant

FATHER
12. Name Hyman Buckner
13. Birthplace Poland

MOTHER
14. Maiden Name Unkown
15. Birthplace Poland

16 (a) Informant Mr Nathan Felsenberg
(b) Address 3406 Cakfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 18, 1948 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cemetery Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 APR 18 1948 (Date rec'd by Registrar) (b) Huntington Wolfinger M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/17 1948 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/16 1948 to 4/17 1948, and that I last saw him alive on 4/17 1948.

Immediate cause of death PERIPERAL VACCULAR COLLAPSE — Duration

Due to MYOCARDIAL INFARCTION

Due to CORONARY ARTERIOSCLEROSIS

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Gabrielly
Address Mount Bettania Emanuel Hosp Date signed 4/19/48

VS 153

X

Please write plainly, with INDELIBLE INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G62359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G62359 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2125 Callow ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2125 Callow ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Adele Levinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: W.

6 (b) Name of husband or wife: late Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. **AGE:** Years: 84 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER
12. Name: Abraham Beitchman
13. Birthplace: Russia

MOTHER
14. Maiden Name: N. K.
15. Birthplace: Russia

16 (a) Informant: Morris Lebow
(b) Address: 2125 Callow ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: April 18/48 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Washington Blvd
Location: Near Sulfor Spring Road

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 424-26 N. North ave

19 (a) (Date rec'd by registrar) (b) Registrar

APR 18 1948

MEDICAL CERTIFICATION

20. **DATE OF DEATH** April 17 1948, at 3:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10 1948 to 4/17 1948.
and that I last saw her alive on 4/17 1948.

Immediate cause of death
Acute Coronary Insufficiency
Due to Ch. Coronary Sclerosis
Due to Ch. Myocarditis
Other Conditions Ch. Hypertension

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. **Signature** M. L. Hornstein M. D.
Address 204 E. Biddle St Date signed 4/17/48

V S 150

662360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

662360 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3401 Dolfiel Ave
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 48 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3401 Dolfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Morris Behrman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jeanette

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept, 25, 1887

8. AGE: Years 60 | Months 6 | Days 26 21 | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: Behrman
13. Birthplace: Russia

MOTHER
14. Maiden Name: Unkown
15. Birthplace: Russia

16 (a) Informant: Mrs Jeanette Behrman
(b) Address: 3401 Dolfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 18, 1948 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Friendship Cemetery
Location: 3600 E Baltimore St

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 (a) (Signature of registrar) (b) Huntington Williams, M.D. Registrar
Registered APR 18 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 19 48, at 9.30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1st 1948, to April 16 1948, and that I last saw h[illegible] alive on April 16 1948.

Immediate cause of death: Coronary Thrombosis — Duration: 1/2 hr

Due to: Arteriosclerosis

Due to: Diabetes

Other Conditions: Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. T. Lisanby
Address 3210 Edgewood Road Date signed April 19, 1948

E. T. Lisanby

C62361

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

C62361 Registered No. 3698

121a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1034 Stricker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) none 16
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1034 Stricker St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Johnson
(b) If veteran, name war
(c) Social Security Account No.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	colored	single

6 (b) Name of husband or wife
6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) Dec 1871

8. AGE: Years 76 | Months — | Days — | If less than one day: hr. — min —

9. Birthplace Eastern Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

MOTHER / FATHER
12. Name Joseph Johnson
13. Birthplace Eastern Md
14. Maiden Name Unknown
15. Birthplace Eastern Md

16 (a) Informant James Fletcher
(b) Address 1034 Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 19, 1948 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Cemetery
Location Baltimore, City

18 (a) Funeral director Joseph A. Sisty
(b) Address 66 West Baltimore St

19 (a) APR 18 1948 (Date rec'd by registrar) Limiting for Insurance Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 — 16 1948, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-17-1947 to 4-16-1948. and that I last saw her alive on 4-15-48.

Immediate cause of death — **Duration**

Nephritis — unknown

Due to

Due to

Other Conditions Myocarditis and arteriosclerosis — unknown
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 029 N. Stricker Date signed 4-17-48

VS 150

X

G62362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓46E

G62362
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4204 Oakford Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4204 Oakford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joe Blum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years ✓6 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Herch
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Rebecca Blum
(b) Address 4204 Oakford ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-18-28 (month) (day) (year)

(c) Cemetery or crematory Hebrew Young Men
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 406 Eastern Ave

19 (a) (Date received by Registrar) APR 18 1928 (b) Huntington Printing Co

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-16-1928, at 10:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1927 to April 16 1928, and that I last saw h alive on April 16 1928.

Immediate cause of death
Carcinoma of Colon
Due to

Due to

Other Conditions with metastases to bones & liver & lung
(Include pregnancy within 3 months of death)

Date of operation ?

Major findings of operation: Carcinoma of Colon + Metastases

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at P.M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature S. T. Kusansky M.D.
M. D.
Address 3217 Liberty Hgts Date signed April 17/28

G62363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G62363 Registered No. 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd + Calvert

(c) Hospital or institution Union Memorial Hospital W

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto

(c) City or town Balto 12 (If outside city or town limits, write RURAL and give town)

(d) Street No. 5505 York Rd (If rural give location)

(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Leon Terl

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Hannah Terl

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/20/08

8. AGE: Years	Months	Days	If less than one day: hr.	min.
39	10	16		

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Hardware merchant

11. Industry or business

FATHER

12. Name Israel Terl

13. Birthplace Russia

MOTHER

14. Maiden Name Pearl ?

15. Birthplace Russia

16 (a) Informant Wife

(b) Address 5505 York Rd Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-18-48 (month) (day) (year)

(c) Cemetery or crematory Beth Tfiloh Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc

(b) Address 2160 Eutaw Place

19 APR 18 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1948, at 9:32 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 1948 to April 16 1948, and that I last saw h[illegible] alive on April 16 1948

Immediate cause of death

Coronary occlusion — Duration: -

Due to Coronary sclerosis — 3 yr

Due to A-S heart disease — 3 yr

Other Conditions Multiple pulmonary emboli — 3 mo

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary emboli Coronary occlusion

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?

(e) Means of injury

23. Signature H. R. Freeman Jr.

Address Union Memorial Hosp Date signed April 16, 19

VS 150

G62364

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G62364 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3725 Columbus Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3725 Columbus Drive (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME (Mrs.) Goldie Siegel
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband ~~wife~~ Max Siegel
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) not known
8. AGE: Years 90 yrs | Months | Days | If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation At home
11. Industry or business —

FATHER
12. Name Hyman Markoff
13. Birthplace Russia

MOTHER
14. Maiden Name Chasa Markoff
15. Birthplace Russia

16 (a) Informant Esther Friedman
(b) Address 3725 Columbus Drive
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-18-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt. Carmel
Location
18 (a) Funeral director Jack Lewis Inc.
(b) Address 2306 Eutaw Place
APR 19 1948
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1948 at 8a M
21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1948 to Apr. 16 1948 and that I last saw h alive on Apr 16 1948.

Immediate cause of death: Coronary occlusion arterio sclerosis — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Kaden M. D.
Address 2306 Eutaw Pl Date signed 4-20-48

VS 150

Huntington, Washington, D.C.

G62365

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 153

G62365 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cornelia Terry

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. 12-28-13

8. AGE: Years 34 | Months - ? | Days - 11 | If less than one day — hr. — min.

9. Birthplace NC (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Henderson Terry

13. Birthplace N.C.

MOTHER 14. Maiden Name Mary Bullock

15. Birthplace N.C.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-48 (month) (day) (year)

(c) Cemetery or crematory Rocky Mt. N.C. Location N. C.

18 (a) Funeral director George A. Nelson

(b) Address 1303 Presstman St

APR 18 1948 (Date rec'd by registrar) (b) Registrar

VS (50)

Remarks for Williamsville, N.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-16-48, at 0115 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-3-48 to 4-16-48, and that I last saw h[er] alive on 4-16-48.

Immediate cause of death

Due to Exfoliative Dermatitis — Duration 1 mo.

Due to

Other Conditions Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy [illegible]

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. A. Gibson

Address Johns Hopkins Hosp. Date signed 4-19-48 M. D.

X

JL - 118972 G662366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G662366

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City HOspitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4314 La Salle Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward M. Kolb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Adelle M. Dillmeyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1894

8. AGE: Years	Months	Days	If less than one day
53	9	13	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation U. S. Post Offic
11. Industry or business

FATHER
12. Name Nicholas Kolb
13. Birthplace Md.

MOTHER
14. Maiden Name Mary ?
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director Leonard J. Rucks
(b) Address 5300 Harford Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

APR 18 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15, 1948, at 9.43 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1948 to April 15 1948, and that I last saw h. alive on April 15 1948.

Immediate cause of death Cerebral Hemorrhage — Duration —
Due to Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: not done.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Beadian M. D.
Address Balto 24 Hosp Date signed Apr 18 48

To Be approved by Medical Examiner

Earl Rogers M.D.

C62367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 182

C62367
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3708 Ridgecroft Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dominic Folis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 5 1900

8. AGE: Years 48 | Months 1 | Days 10 | If less than one day: hr min

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business City

FATHER
12. Name Dominic Folis
13. Birthplace Italy

MOTHER
14. Maiden Name Margaret Schiavetta
15. Birthplace Italy

16 (a) Informant Mr. John Folis
(b) Address 3708 Ridgecroft Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Leonard J. Leuck
(b) Address 5305 Harford Rd

19 APR 18 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1948 at 3:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Drowning

Due to

Other Conditions acute alcoholism

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-15-48 at 2:00 P.M.
(b) Where did injury occur? Eastern & Fells Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Harbor (While at work?) no
(d) Means of injury Jumped or fell into harbor

23. Signature [signature] M.D.
Medical Examiner
Date signed 4-16-48

VS 151

X

662368

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

662368
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3227 Keswick Road
(c) Hospital or institution:

13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3227 Keswick Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Leah Follett

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Charles E. Follett
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr Oct 12 - 1879

8. AGE: Years 68 | Months 6 | Days 5 | If less than one day hr min

9. Birthplace York Co. Pennsylvania (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name George K. Zinger
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Rasmar
15. Birthplace Pennsylvania

16 (a) Informant Ray L. Brewer
(b) Address 56 Chateau Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 20-1948 (month, day) (year)
(c) Cemetery or crematory Brooked Hill
Location York Pennsylvania

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) DR 18 (date rec'd by registrar) (b) Hunting to [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 - 1948, at 3-30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 16 1948 to Apr. 17 1948 and that I last saw h[illegible] alive on Apr. 11 1948.

Immediate cause of death: Coronary Thrombosis — Duration 4 Hrs

Due to: Coronary Artery Dis.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Edward J. Glassman M D
Address 4037 Falls Rd. Date signed 4/18/48

X

VS 150

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C62369

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 927

C62369

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2910 Presstman St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 Presstman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY S. MORSE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife WILLIAM A.
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr OCT. 30 1870

8. AGE: Years	Months	Days	If less than one day
77	5	17	hr. min.

9. Birthplace FEDERALSBURG MD. (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name DANIEL R. FLUHARDY
13. Birthplace FEDERALSBURG MD.

MOTHER
14. Maiden Name ELIZABETH CAULK
15. Birthplace FEDERALSBURG MD.

16 (a) Informant MISS GRACE MORSE
(b) Address 2910 Presstman ST. BALTIMORE 16 Md.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APRIL 20 1948 (month) (day) (year)
(c) Cemetery or crematory FEDERALBURG
Location FEDERALSBURG MD.

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address NORTH & PENNSYLVANIA AVES.

19 (a) Date received by registrar (b) Registered number

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 17 1948, at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 29 1947 to April 17 1948 and that I last saw h alive on April 15 1948.

Immediate cause of death
(a) Hypertension C-V-D
(b) Cerebral hemorrhage

Duration
(a) 1 Year
(b) 1 Year

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Geo. Coleman, M.D.
Address 2910 Presstman St. Date signed 4-18-48

VS 199

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G62370 HL 118998 G62370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 8 1a

Registered No. G62370

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .... 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 6110 Plantview Way (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alvin Leroy Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age ____ years

7. Birth date of deceased mo., day, yr

8. AGE: Years	Months	Days	If less than one day: hr.	min.
3	0	16		

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Carl Lewis

13. Birthplace Ill.

MOTHER

14. Maiden Name Jeanette E. Johnson

15. Birthplace Va.

16 (a) Informant B.C.H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Morland Park

Location Parkville Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

19 APR 18 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16. 19 48 at 8-20-A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 16, 1948 to April 16, 19 48. and that I last saw him alive on April 16 19 48.

Immediate cause of death

Due to Meningitis (Type ascertained)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not done

Duration: 1 day

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (While at work)

(e) Means of injury

23. Signature Julian P. Griffin

Address Balto City Hosp. Date signed 17 Apr. 48

VS 150

To be approved by Medical Examiner

G62371 G62371

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

B.M.117107 /121 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 Sterrett St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maywood Nelsom or Maywood Daffin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Harry L. Daffin
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr Nov. 28, 1897

8. AGE: Years	Months	Days	If less than one day
50	4	18	hr min

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name William Wilkins
13. Birthplace Virginia

MOTHER
14. Maiden Name Sally Peed
15. Birthplace Va.

16 (a) Informant B.C.H.Records
(b) Address 4940 EasternAve.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/19/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (Date rec'd by registrar) APR 18 1948 (b) Huntington Indiana, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-16-48 19 , at 10:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1 19 48 to 4-16 19 48 and that I last saw her alive on 4-16- 19 48

Immediate cause of death Bronchopneumonia. Duration a days

Due to

Due to

Other Conditions appendicial abcess ??
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: ———

of autopsy Bronchopneumonia typhoid? abcess.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature D E Groce M. D.
Address 4940 Eastern Ave Signed 4-17-48

PHYSICIAN
Underline the cause to which death should be attributed.

107

G62372 ✓ 47

B.M.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred Charpcrow (FREDERICK CHARPACKOW

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28 1888

8. AGE: Years	Months	Days	If less than one day
60 ?	1	17	hr. min.

9. Birthplace Russia (Town, county, and State)

10. Usual Occupation Cement Finisher

11. Industry or business

FATHER
12. Name Nicholas Charpackow
13. Birthplace Russia

MOTHER
14. Maiden Name Antoinette Brown
15. Birthplace ? Records Russia

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremation (Burial, cremation, removal) (b) Date thereof 4/19/48 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-15- 1948 9:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-15- 1948 to 4-15- 1948 and that I last saw h im alive on 4-15- 1948.

Immediate cause of death
Respiratory failure
Due to Pleural effusion
Due to ? Carcinoma (Lung)
? Tuberculosis
Other Conditions
Malnutrition
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Not done

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. T. Binford M. D.
Address Balt. City Hosp Date signed 4-17-48

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G62373

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G62373

94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai
(c) Hospital or institution Hospital
(d) Length of stay in hospital or inst. yrs., mos., or days 11
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? Yes or No)
If yes, name country

3 (a) FULL NAME Clarence C Cappel (CAPPEL)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Helen W. Cappel

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr: Mar 25th 1887

8. AGE: Years: 61 | Months: 0 | Days: 21 | If less than one day: hr. min.

9. Birthplace: Ulrichsville Ohio
(Town, county and state)

10. Usual Occupation: Manager

11. Industry or business: Concert

FATHER
12. Name: Cappel
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant: Mrs. W. O. Ware
(b) Address: 1112 N. Calvert St

17 (a) Cremation (b) Date thereof: 4/19/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Green Mount
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 217 St. Paul St

Apr 18 1948
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-16 19 48 at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-9 19 48 to 4-16 19 48 and that I last saw h/ alive on 4-14 19 48

Immediate cause of death: Cardiac failure

Due to: Coronary thrombosis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or Town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature: A Friedman M. D.

Address: Sinai Hosp Date signed

X

662574

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

170C

662574
Registered No.

Instructions: PRINT plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County Anne Arundel
(c) City or town Linthicum Heights
(If outside city limits, write RURAL and give town)
(d) Street No. 504 Ft. Meade Road
(e) Citizen of foreign country? (Yes or No)
If yes, name country,

3 (a) FULL NAME Charles DOETZER

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No. 219-07-2079

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife (Nee Bange): Katherine A. Doetzer

6 (c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): February 23, 1916

8. AGE: Years: 32. Months: 1 Days: 23 If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Carpenter

11. Industry or business: Oregon Neighoff, Builder

FATHER
12. Name: John J. Doetzer
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Louretta C. Witte
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Charles Doetzer
(b) Address: 504 Ft. Meade Road Linthicum

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/19/48

(c) Cemetery or crematory: Louden Park
Location: Baltimore, Md.

18 (a) Funeral director: Thomas W. Singleton
(b) Address: [illegible] Bmore

19 APR 18 1948 (b) (Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16, 1948 at 8:05 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the cause of death were

IMMEDIATE CAUSE OF DEATH: Fracture of skull

Contusions of brain.

Fractured ribs.

Rupture of aorta.

Fractured femur.

Other Conditions: Fractured facial bones

Multiple lacerations and contusions

(Include pregnancy within three months of death)

22. If an external cause was Primary ☑ or Contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-16-47 at 7:45 A.M.
(b) Where did injury occur? Glen Burnie Anne Arundel County
(c) Did injury occur at home, on farm, industrial place, in public place) Public While working? No
(d) Means of injury: Auto. & Auto. (Pedestrian - Passenger)

23. Signature: George G. Merrill M.D.
Medical Examiner.

Date signed: 4/16/48

VS 151

G62375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G62375 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1823 N. Mount St.

(c) Hospital or institution:

15-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1823 N. Mount St. (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Mary C. Fest

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1873

8. AGE: Years	Months	Days	If less than one day
74 75	6	11	hr. min

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Edward Fest

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden Name Unknown

MOTHER 15. Birthplace

16 (a) Informant Mrs. Mary Fest Cox Jr.

(b) Address 1823 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mrs. George A. Holland

(b) Address 1691 Druid Hill Ave.

19 (a) [illegible] (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 14 - 1948 at 8:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to April 1948, and that I last saw h[illegible] alive on 4 - 12 1948.

Immediate cause of death	Duration
1	
Due to Chr Nephritis	3 years
Due to Chr Tuberculosis	2 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Calvin B. Le Compte M. D.

Address 1118 N Caroline St Date signed 4/15/48

VS 150

1162376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. 1162376

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2431 Frances St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2431 Frances St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mary Lee Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married (W)

6 (b) Name of husband or wife John Theodore Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1, 1868

8. AGE: Years 80 | Months | Days | If less than one day hr. min

9. Birthplace Scotland Neck, N.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Hester Pinkett

15. Birthplace Scotland Neck, N.C.

16 (a) Informant J. Theodore Jones, Sr.

(b) Address 2450 N. 12th St. 4-4-27

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-1948 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Mem. Park

Location Baltimore Co. Md.

18 (a) Funeral director Geo. H. Hyde

(b) Address 1631 Druid Hill Ave.

19 (Signature and title of person who filed certificate) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-14 1948 at 10 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1948 to 4/17 1948 and that I last saw him alive on 19

Immediate cause of death: Cerebral Hemorrhage — Duration 4 days

Due to Hypertension — 3 mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Welcome M.D.

Address 1137 Hollins St. Date signed 4/16/48

VS 150

G62377

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

51B

G62377 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1424 Druid Hill Ave
(c) Hospital or institution: —
14-V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Samuel E. Hatton

3 (b) If veteran, name war —
3 (c) Social Security Account No. 212-20-2608

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife Elizabeth Hatton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1863

8. AGE: Years	Months	Days	If less than one day
84	7	1	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Tagmatic
11. Industry or business Robbins Paper Co.

FATHER
12. Name David Hatton
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Downey
15. Birthplace Md.

16 (a) Informant Marita H. Daniels (daughter)
(b) Address 1424 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 19, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Thos. McJunkin
(b) Address 1706 Druid Hill Ave.

19 (a) Apr 18 1948 (Date received by Registrar) (b) Pennington Wm. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 16" 1948, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1 19 48 to 4/16 19 48 and that I last saw him alive on 4/16 19 48

Immediate cause of death Carcinoma Prostate
Due to Stone
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury —

23. Signature R. D. Hatcher
Address 1725 Park Ave Date signed 4/17/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

662378

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1948

662378
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2739 E. Ireston street
(c) Hospital or institution: 2-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 61 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County - - -
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2739 E. Ireston
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE DORAN LESLEIN

3 (b) If veteran, name war ----
3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	widow

6 (b) Name of husband or wife William Leslein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23, 1868

8. AGE: Years	Months	Days	If less than one day: hr.	min.
80	2	22		

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name James Campbell
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. Edward F. Curran
(b) Address 2739 E. Ireston street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 4/13/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Eggers & Son Inc.
(b) Address 118 N. Mt. Royal Ave.

19 (a) (Date received by Registrar) (b) Registrar

APR 15 1948

NVS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1948 at M

21. I certify that death occurred on the date above stated, that I attended deceased from 3-9 1948 to 4-13 1948.
and that I last saw h[illegible] alive on 4-13 1948.

Immediate cause of death

Due to (a) Cardiac Decompensation — Duration 2 days
Due to (b) Uraemia
Due to (c)
Other Conditions Post Embolism — 1 dy

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) (While at work)
(e) Means of injury

23. Signature J. Fred Rupp M.D.
Address 600 N. Wolfe St. Date signed 4-16-48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 662379

662370 — 937

1. PLACE OF DEATH: 20-1
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2025 Fayette St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Jennie McCann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 70 Unknown 70? | Months | Days | If less than one day: hr. min.

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation Store-keeper

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-48 (month, day, year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director George A. Fowler
(b) Address Fulton Ave & Fayette St

19 (a) Filed by registrar (b) Washington Heights, Md. Registrar

APR 18 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1948, at 9 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 11 1948, to Apr. 14 1948, and that I last saw her alive on Apr. 14 1948

Immediate cause of death: Cerebral Hemorrhage — Duration: 4 days

Due to Hypertension cardio-Vascular disease — unk.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Frederick E. Bartel Jr. M.D.
Address Bon Secours Hosp. Date signed 4/14/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

662380

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 662380 Registered No. 42a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1917 W. Fayette St
(c) Hospital or institution: 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 W. Fayette St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth C Ingram

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Harry A
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 7-16-1863

8. AGE: Years	Months	Days	If less than one day
84	9		hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Hogan
13. Birthplace England

MOTHER
14. Maiden Name Cochran
15. Birthplace Ireland

16 (a) Informant Miss Marie Ingram
(b) Address 1917 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-20-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Georgia Farley
(b) Address Fulton Ave & Fayette St.

19 (a) Filed (Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/17 1948, at 7 am M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/8 1948 to 4/17 1948
and that I last saw her alive on 4/14 1948

Immediate cause of death
Cerebral Hemorrhage — Duration 3 days.
Due to Arteriosclerosis — Duration 8 yrs.
Due to Bronchopneumonia — Duration 3 wks.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?) (Specify)
(e) Means of injury

23. Signature [signature]
Address 1933 Eutaw St Date signed 4/17/48

VS 150

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C62381 1751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. C62381

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2357 W. North Ave
(c) Hospital or institution: 15-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2357 W. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Mayfield Sr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	M.

6 (b) Name of husband or wife Sarah E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1857

8. AGE: Years	Months	Days	If less than one day: hr.	min.
90	6	21	20	

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Building Business

FATHER
12. Name George W. Mayfield
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Matilda Seymour
15. Birthplace Prince Georges Maryland

16 (a) Informant Fabyan Mayfield
(b) Address 123 Ridgewood Ave

17 (a) Burial (b) Date thereof 4/19/48
(burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lorraine
Location Balto Co Maryland

18 (a) Funeral director Strong Bippus
(b) Address 5005 Park Heights Ave

19 (a) [illegible] Huntingtown Calvert Co. Md
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1948, at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/12 1948 to 4/16 1948.
and that I last saw h[illegible] alive on 4/16 1948.

Immediate cause of death Coronary Thrombosis — Duration 1 mo

Due to Arteriosclerosis

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Edward S. Harding M.D.
Address 1847 W. North Ave Date signed 4/17/48

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

VS 150

G62382

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46E

Registered No. G62382

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3626 W. Belvedere Ave Z-15
(c) Hospital or institution: 27-18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore yrs., mos., or days 55yrs 8mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore, 15 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3626 West Belvedere (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Emma Christina Russell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Marshall R. Russell
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) July 24, 1892

8. AGE: Years	Months	Days	If less than one day
55	8	17	hr. 14 min.

9. Birthplace Baltimore (Town, county, and state) Maryland
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph James Weller
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Mary French Weller
15. Birthplace Baltimore Md.

16 (a) Informant Bessie Mears (sister)
(b) Address 5218 Florence Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-20-48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Lazenby Bros
(b) Address 5005 Park Heights Ave.

19 Apr 19 1948 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1948 at 2:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from October 20 1947 to April 17 1948, and that I last saw h e r alive on April 17 1948.

Immediate cause of death: Respiratory Failure — Duration: 24 hours

Due to Carcinoma of Large Bowel with Metastases — Duration: 2 years

Due to

Other Conditions

(Include pregnancy within 3 months of death.)

Date of operation October 1, 1947

Major findings of operation: Carcinoma of Large Bowel with Metastases

of autopsy: None Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Millard T. Trealand, Jr. M.D.
Address 3400 Woodbine Ave. Z-7 Date signed 4/17/48

VS 150

G62383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

133 B

Registered No. G62383

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in Baltimore (yrs., mos., or days —

2. USUAL RESIDENCE OF DECEASED:

(a) State Pa. County

(c) City or town Uniontdale (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Elsie E. Tarom

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-16-47

8. AGE: Years 8 Months Days 2 If less than one day hr. min.

9. Birthplace Johnstown, Pa. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Peter Tarom

13. Birthplace Uniontdle, Pa.

MOTHER 14. Maiden Name Elsie Smith

15. Birthplace Milwaukee, Wis.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 21, 1948 (month) (day) (year)

(c) Cemetery or crematory (?)

Location Penna.

18 (a) Funeral director Wells Berge Bradley

(b) Address 1922 W. North Ave.

19 APR 19 1948 at Huntingdon Williams, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-18-48 at JNP M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-18 1948 to 4-18 1948.

and that I last saw it alive on 19

Immediate cause of death aspiration of Vomitus

Duration

Due to

Due to

Other Conditions NEPHROSIS

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature James Hillyard Haught M.D.

Address Johns Hopkins Hosp Date signed 4-18-48

VS '51

James Hillyard Haught

G62384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G62384 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution 9-8 Jewish Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town (If outside city limits, write RURAL and give town) 1905 Bonaparte Pl Baltimore Md
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emanuel Schwartz

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 218-18-3490

4 Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret A.

If married, give age years

7. Birth date of deceased (mo., day, yr.): Sept 9, 1895

8. AGE: Years 52 | Months 7 | Days 8 | If less than one day: hr. min.

9. Birthplace (City, county and state): Baltimore Md (Town, county and state)

10. Usual Occupation: Agent

11. Industry or business: Lafayette Theatre

FATHER
12. Name: Jacob Schwartz
13. Birthplace: Md

MOTHER
14. Maiden Name: Margaret Stern
15. Birthplace: Md

16 (a) Informant: Margaret A. Schwartz
(b) Address: 1905 Bonaparte Pl

17 (a) Burial, cremation or removal: Burial (b) Date thereof: 4/21/48

(c) Cemetery or crematory: Woodland Park
Location: Baltimore Md

18 (a) Funeral director: Wilson Sons Co
(b) Address: 1219 Eutaw St

APR 19 1948 (Date received by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr 17 1948, at 12 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Generalized arteriosclerosis
Pulmonary edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary or contributing cause of death, fill in the following
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in street, place, in public place? (Specify)
(d) Means of injury

23. Signature: Emanuel Rosen M.D.
Medical Examiner
Date signed 4/19/48

VS 181

662385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170C

662385
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 9-9
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos. or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, give R.F.D. and give town)
(d) Street No. 915 E. Hoffman St.
(If rural, give location)
(e) Citizen of foreign country? Yes or No?
If yes, name country

3 (a) FULL NAME Thelma Mae Bosley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 1st 1931

8. AGE: Years	Months	Days	If less than one day: hr. min.
17	1	16	

9. Birthplace Balto. Co. Md
(Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm T. Bosley
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Mary Hunt
15. Birthplace Glyndon Md.

16 (a) Informant Wm T. Bosley
(b) Address 915 E. Hoffman St

17 (a) Burial (Burial, cremation, removal) (b) Date (Burial, cremation, removal) 4/20/48

(c) Cemetery or crematory Mt. Carmel
Location Rockland Md Balto Co

18 (a) Funeral director Gilbert Bros
(b) Address 1911 E. Fayette St

19 APR 19 1948
(Date rec'd by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1948 3:05 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon, and from the evidence obtained
(Autopsy, Inspection or Inquest)
by said Autopsy Inspection or Inquest, find that said deceased came to her death on the day stated above, and death in my opinion resulted from natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Cerebral concussion

Due to

Other Conditions

22. If an external cause was primary ☑ contributing ☐ cause of death, fill in the following
(a) Date of injury 4-17-48 at 1:30 A.M. P.M.
(b) Where did injury occur? Patuxent Hwy + 11th Ave.
Did injury occur at home, on farm, industrial place, in public place? Public Yes or No? no
(d) Means of injury Fall from bicycle - motorcycle

23. Signature [signature] M.D.
Medical Examiner
Date signed 4-17-48

VS 181

G62386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G62386

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4-1
(c) Hospital or institution Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 233 PARK AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sophia Lusby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	WIDOWED

6 (b) Name of husband ~~or wife~~ Wm WOODFIN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 14, 1887

8. AGE: Years	Months	Days	If less than one day
60	11	2	hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name SIMON WERNER
13. Birthplace GERMANY

MOTHER
14. Maiden Name ANNIE KELLEKER
15. Birthplace BALTO. MD.

16 (a) Informant MRS JOHN C ZINK (SISTER)
(b) Address 6117 BELLONA AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APRIL 19 '48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PK
Location 3801 FREDERICK AVE

18 (a) Funeral director Harry H Withe
(b) Address 4101 Edmondson Ave Huntington Williams, M.D.

APR 19 1948 (Date received) (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16th 1948 at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 1948 to April 16 1948 and that I last saw h-- alive on April 1. 1948.

Immediate Cause of death: Bronchopneumonia — Duration 2 days

Due to

Due to

Other Conditions Arteriosclerotic Cardiovascular disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Kilbreck M. D.

Address 5006 Roland Ave Date signed April 16, 1948

107

VS 150

62387 ✓ 62387

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 19-3
(b) Street address Fayette + Calhoun St.
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miller, Carrie.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ late THOMAS V MILLER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 6, 1871

8. AGE: Years	Months	Days	If less than one day
76	11	11	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name ? CARLISLE
13. Birthplace —

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant MR. W.H.C. VINCENT
(b) Address 1528 HOLLINS ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APRIL 20 '48 (month) (day) (year)
(c) Cemetery or crematory MT OLIVET
Location 2930 FREDERICK AVE

18 (a) Funeral director Harry A Wiltse
(b) Address 4101 Edmondson Ave

19 APR 19 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17, 1948 at 4 05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-7-1948 to 4-17 1948, and that I last saw her alive on 4-12-1948

Immediate cause of death Cardiac failure — Duration

Due to Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert K Remenda M. D.
Address Helen Hay Whitney Clinic Date signed 4/17/48

G62388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 84B

Registered No. G62388

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp 20-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 wks.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3344 E. ~~North~~ Avenue (If rural give location)
(e) Citizen of foreign country? ~~Eng~~ Wales (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie ~~G~~ Meta Alexander (Elsie Meta Alexander)

3 (b) If veteran, name war: No
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife: Charles H. Alexander
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Jan 29, 1893

8. AGE: Years	Months	Days	If less than one day
55	2	13	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: William J. Jones
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Meta Jones
15. Birthplace: Wales

16 (a) Informant: Charles H. Alexander
(b) Address: 3315 E. Lombard Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/48 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 APR 19 1948 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-16 1948, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/23/48 19 to 4/16/48 19; and that I last saw her alive on 4/16/48 19

Immediate cause of death — Duration

(a) Respiratory failure due to
(b) Cerebral thrombosis due to
(c) Arteriosclerosis due to
(d) Cerebral hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3/17/48

Major findings of operation: Cerebral thrombosis confirmed

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: D. B. Pyatt, M.D.
Address: University Hosp. Date signed 4/18/48

VS 150

X

662389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

662389 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1-1
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6M
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 421 N Streeper St (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Arnold

3 (b) If veteran, name war NO

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife EDGAR ARNOLD

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/23/77

8. AGE: Years 70 | Months 4 | Days 14 | If less than one day hr. min

9. Birthplace GERMANY (Town, county, and state)

10. Usual Occupation TAILOR

11. Industry or business KAYLON TAILORING CO.

FATHER
12. Name PETER VIOLI
13. Birthplace ITALY

MOTHER
14. Maiden Name ANNA DASSING
15. Birthplace GERMANY

16 (a) Informant ANNA WIEGAND - SISTER
(b) Address 1004 ORLEANS ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/19/48 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD.

18 (a) Funeral director SCHMUNK FUNERAL HOME INC
(b) Address 2601-05 E. MADISON STREET.

APR 19 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Name)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1948 at 12:35 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to for death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral haemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William S. Kefferich M.D. Medical Examiner
Date signed 4/17/48

G62390

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G62390
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Sorrento Road
(c) Hospital or institution: Colonial Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 East 29th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Daisy B. Maxwell

3 (b) If veteran, name war

3 (c) Social Security Account No. 715-01-7368

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Coleman R.

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 2 1875

8. AGE: Years: 72 | Months: 9 | Days: 13 | If less than one day: hr. ____ min. ____

9. Birthplace: Phila Penna (Town, county, and state)

10. Usual Occupation: Retired Seamstress

11. Industry or business

FATHER
12. Name: James McKitrick
13. Birthplace: Md

MOTHER
14. Maiden Name: Alice L. Buckingham
15. Birthplace: Md

16 (a) Informant: Gertrude Hoffman
(b) Address: 1519 East 29th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: April 19-1948 (Mo.) (Day) (Year)
(c) Cemetery or crematory: Loudon Park
Location: Balto Md

18 (a) Funeral director: H C & B M Walker
(b) Address: Pratt & Stricker Sts

19 APR 15 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15th 1948 at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1947 to 15 Apr 1948 and that I last saw h[illegible] alive on 15 Apr 1948.

Immediate cause of death: Cerebral Hemorrhage, Spontaneous

Due to

Due to Hypertension C.V. Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature: Earl L. Coyle, M.D.
Address 1712 Eutaw St Date signed April 16 1948

G62391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G62391 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2da. 8hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 58yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1427 N. Charles Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Warren Turner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/18/84

8. AGE: Years	Months	Days	If less than one day
56	11	26	hr. min.

9. Birthplace Harford County, Maryland (Town, county, and state)
10. Usual Occupation Block Operator
11. Industry or business Pennsylvania R.R.

FATHER
12. Name John H. Turner
13. Birthplace Magnolia Md

MOTHER
14. Maiden Name Ellen L. Turner
15. Birthplace Magnolia Md

16 (a) Informant Eleuthe A. Turner
(b) Address Magnolia Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 14 1948 (month) (day) (year)
(c) Cemetery or crematory Union Chapel
Location Welby Maryland

18 (a) Funeral director Howard V. McComas
(b) Address Abingdon Maryland

19 (a) APR 15 1948 (Date rec'd by registrar) (b) Huntington for Nathaniel, M.D. Registrar

VS 150 APR 15 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14, 1948 at 10:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/12 1948 to 4/14 1948 and that I last saw him alive on 4/14 1948

Immediate cause of death UREMIA — Duration

Due to MALIGNANT NEPHRO-SCLEROSIS

Due to HYPERTENSIVE CARDIOVASCULAR DISEASE

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

Findings of autopsy NEPHROSCLEROSIS; CARDIAC HYPERTROPHY; PULMONARY CA

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E May

Address 1400 N. Caroline St. Date signed 4-14-48

062392

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 108

Registered No. 062392

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1331 Mosher St
(c) Hospital or institution: 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1331 Mosher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard Lamback
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1941

8. AGE: Years 6 | Months 7 5 | Days 5 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Arthur (Sonny) Lamback
13. Birthplace Md.

MOTHER
14. Maiden Name Rachael Mitchell
15. Birthplace Md.

16 (a) Informant Lillian Fowles
(b) Address 538 St. Marys' st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-48
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles L. Law
(b) Address 801 Madison Ave

19 (a) APR 19 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1948, at 7 20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within three months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (Specify which)
(d) Means of injury

23. Signature Earl L. Royle M.D. Medical Examiner.
Date signed 4-17-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

62393 JL - 51594

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 137a

Registered No. 62393

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 10-1
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 732 Mura St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel O'Connell

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 2-4, 1867

8. AGE: Years 78 69 ? Months 10 Days 7 If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Dennis, O'Connell
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Rardon
15. Birthplace Ireland

16 (a) Informant B. C. Hosp. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 20 48 (month) (day) (year)
(c) Cemetery or crematory New Catholic Cemetery
Location 4300 Rd Frederick Rd

18 (a) Funeral director Edgar W. Cookliss & Son
(b) Address 224 E. Eager St.

19 APR 19 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17, 19 48, 2.30A M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan. 1, 19 40, to April 17, 19 48 and that I last saw h im alive on April 17 19 48

Immediate cause of death: Bronchial pneumonia — Duration 4 days.

Due to

Due to

Other Conditions Chronic Urinary tract infection (Include pregnancy within 3 months of death) — Duration 1 month

Date of operation 1-26-48

Major findings of operation: benign prostatic hypertrophy

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D E Greve M. D.
Address 4940 Eastern Ave Date signed 4-17-48

VS (S)

C62394

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 130

Registered No. C62394

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert 25-V

(c) Hospital or institution: Mercy

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2 mo.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2012 Deering ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Ann Jeppi

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr	min
	2	1.		

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER	12. Name	Vincent Jeppi
	13. Birthplace	Baltimore
MOTHER	14. Maiden Name	Sadie Rigatuso
	15. Birthplace	Baltimore

16 (a) Informant Walter

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof April 19/48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem

Location

18 (a) Funeral director Joseph Farace Inc

(b) Address 2[illegible] Greenmount ave

19 (a) APR 19 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1948 at 1[illegible] PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 19 1948 to April 19 1948 and that I last saw [illegible] alive on April 19 1948.

Immediate cause of death	Duration
Uremia	
Due to Nephritis ?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature T. M. Corrigan

Address Mercy Date signed 4/19/48

M. D.

VS 130

X

G62395

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G62395

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 556 W. Biddle St.
(c) Hospital or institution: 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 556 W. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Peticolas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1888

8. AGE: Years	Months	Days	If less than one day
59	8	12	hr min

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Edward T. Martin
13. Birthplace Va.

MOTHER
14. Maiden Name Rosa Sneight
15. Birthplace Va.

16 (a) Informant Mr. Calvin Martin
(b) Address 556 W. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) APR 19 1948 (Date rec'd by registrar) (b) [illegible]

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16, 1948, at 4A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15, 1948 to April 16, 1948.
and that I last saw her alive on April 15, 1948.

Immediate cause of death: Cerebral hemorrhage — Duration 2 hr

Due to

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 73 W. Saratoga St. Date signed 4/19/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

62396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163 H

Registered No. 62396

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Patapsco Ave
(c) Hospital or institution: 25.4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Patapsco Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Fannie S. Upton

3 (b) If married, name wife Mrs. Edmund F. Upton

3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Fannie S. Upton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 3-1891

8. AGE: Years 56 | Months 4 | Days 14 | If less than one day 15 hr min

9. Birthplace Penna (Town, county, and state)

10. Usual Occupation Tavern Owner

11. Industry or business

FATHER
12. Name Edmund F. Upton
13. Birthplace Md

MOTHER
14. Maiden Name Mary A. Collins
15. Birthplace Md

16 (a) Informant Fannie S. Upton
(b) Address 901 Patapsco Ave

17 (a) Burial
(b) Date thereof April 21-1948
(Burial, cremation, or removal)
(c) Cemetery or crematory Cedar Hill A A Co Md
Location

18 (a) Funeral director Edward Longnecker
(b) Address 359 Washington Blvd

19 (a) APR 19 1948 (b) Date rec'd by registrar Baltimore, Md. by

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-18 1948 at 6:40 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Illuminating gas

Other Conditions Carcinoma of stomach Disseminated
(Include pregnancy within three months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-18-48 at 7 A M.
(b) Where did injury occur? 901 Patapsco Ave
(c) Did injury occur at home, on farm, industrial place, in public place? (While at work) Home No
(d) Means of injury Open gas jet in kitchen stove

23. Signature [illegible] M.D.
Medical Examiner

Date signed 4-18-48

VS 181

C62397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. C62397

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2364 Washington Blvd
(c) Hospital or institution:
2-3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2364 Washington Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse L Young

3 (b) If veteran, name war None

3 (c) Social Security Account No. 225-10-1172

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Flossie G. Young

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 1897

8. AGE: Years 50 | Months 11 | Days 18 ? If less than one day hr. min

9. Birthplace Charlotte N. Carolina (Town, county, and state)

10. Usual Occupation Foreman
11. Industry or business Trucking Co

FATHER
12. Name John Young
13. Birthplace N.C.

MOTHER
14. Maiden Name Nettal ?
15. Birthplace N.C.

16 (a) Informant Flossie G Young
(b) Address 2364 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21-48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Wash D C

18 (a) Funeral director Edward Faulcon
(b) Address 2359 work Blvd

19 (a) APR 19 10 (b) (Signature of registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1948 at 5-05 P M

21. I certify that I took charge of the remains described above, held an Aug & Insp (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to
illuminating gas

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 18 1948 at 5-05 P M
(b) Where did injury occur? 2364 Washington Blvd
(c) Did injury occur at home, on farm, industrial place, in public place) At home (While at work?)
(d) Means of injury Open, unlit burner on gas range

23. Signature William F Hyde M.D. (Medical Examiner)
Date signed 4/18/48

VS 181

Please write plainly. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G62398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G62398 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St 10-1
(c) Hospital or institution: Home for the Aged Colored
(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Aloysius Dausch

3 (b) If veteran, name war ✓ (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Wd.

6 (b) Name of husband or wife Emma Clayton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 877

8. AGE: Years	Months	Days	If less than one day: hr	min
70	10			

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Peter Dausch
13. Birthplace ?

MOTHER
14. Maiden Name Pauline Isele
15. Birthplace Maryland

16 (a) Informant Lilly Linley Home
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-21-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director John A. Morgan
(b) Address 3000 E. Balto St

19 (a) APR 19 1948 (Date received by registrar) Kenneth Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1948 at 10.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 16 1948 to April 17 1948 and that I last saw h alive on 19

Immediate cause of death
Thrombosis Coronary Artery — Duration: May
Due to
Due to Arteriosclerosis — 5 yrs
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(e) Means of injury
23. Signature E Gill Hall
Address 1631 E Madison Date signed 4/18/48 M.D.

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

062399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. 062399

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 11-3
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town insert RURAL and give town)
(d) Street No. 444 Orchard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice Murray

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 70 | Months | Days | If less than one day: hr. min.

9. Birthplace: Md. (Town, county, state or foreign country)

10. Usual Occupation: unemployed

11. Industry or business: ?

FATHER
12. Name
13. Birthplace: Md. ?

MOTHER
14. Maiden Name
15. Birthplace: Md. ?

16 (a) Informant: Emma Banks
(b) Address: 444 Orchard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/20/48

(c) Cemetery or crematory Location: Mt. Auburn

18 (a) Funeral director: A. Halstead
(b) Address: 918 Druid Hill ave (Thornton Williams Mgr.)

19 APR 19 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1948 at 9:10 PM

21. I certify that I took charge of the remains described above, held an Autopsy + Inq. thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐; and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary or secondary cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, in farm, industrial place, in public place? (Specify which?)
(d) Means of injury

23. Signature Emily Lyon M.D. (Medical Examiner)
Date signed 4-17-48

VS 181

062400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12B

Registered No. 062400

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.22
(b) Street address
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1030 Pennsylvania Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Jeffries

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17 1878

8. AGE: Years 69 | Months 7 | Days 29 | If less than one day hr. min

9. Birthplace S.C.

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Ned Jefferies
13. Birthplace S.C.?

MOTHER
14. Maiden Name Patsy
15. Birthplace S.C.

16 (a) Informant Rev. Wm. Jefferies
(b) Address 1030 Pennsylvania Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/20/48

(c) Cemetery or crematory Mt Calvary.
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill

19 (a) APR 19 1948 (Date received by registrar) Funeral Home, Inc. Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/15 1948, at 2:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions Bilmoning Tbc
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. R. Gilbrinth M.D.
Medical Examiner.
Date signed 4/20/48

VS 151

937

Dr. Harbold

062401

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92c

Registered No. 062401

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3425 Sinclair Lane
(c) Hospital or institution: 8-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3425 Sinclair Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma F. Gousha

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife George A. Gousha
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Aug. 5, 1894

8. AGE: Years	Months	Days	If less than one day
53	8	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Andrew J. Magill
13. Birthplace Balto.

MOTHER
14. Maiden Name Emma F. Brown
15. Birthplace Balto.

16 (a) Informant Mr. George A. Gousha
(b) Address 3425 Sinclair Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-20-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, #14

19 (a) APR 19 1948 (Date rec'd by registrar) (b) Timothy Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17th, 1948, at 2 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 18 1947 to April 17 1948 and that I last saw her alive on 4-17 1948.

Immediate cause of death: Chronic myocarditis — Duration: 15 years
Due to Rheumatic Heart Disease
Due to
Other Conditions Partial Cleft Palate, Chronic pyelonephritis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Harbold
Address 4706 Harford Road Date signed 4/18/48

VS 153

662402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12 C

Registered No. 662402

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4116 BOARMAN AVE
(c) Hospital or institution: 15-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4116 BOARMAN AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY VERONICA NEWTON

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife CHARLES T. NEWTON
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 28, 1893

8. AGE: Years	Months	Days	If less than one day
54	4	19	hr. min.

9. Birthplace BALTO., MD. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business

FATHER
12. Name JAMES T. CAULFIELD
13. Birthplace ENG.

MOTHER
14. Maiden Name SARA
15. Birthplace MD

16 (a) Informant MR CHARLES T. NEWTON SR
(b) Address 4116 BOARMAN AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/19/48 (month) (day) (year)
(c) Cemetery or crematory WOODLAWN
Location BALTO. CO., MD

18 (a) Funeral director WM. T. TICKNER & SONS
(b) Address BALTO., MD.

19 (a) APR 19 1948 (Date rec'd by registrar) (b) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16. 1948. at 10.34 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1940. to Apr 16 1948.
and that I last saw h[illegible] alive on Apr 15 1948.

Immediate cause of death	Duration
myocarditis	2 MO.
Due to chronic parenchymatous nephritis	about 5 YRS
Due to	
Other Conditions Paralysis Agitans — Parkinson disease (include pregnancy within 3 months of death)	about 15 YRS

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signeture Hallie S. Blatchett M. D.
Address 2220 Harrison Blvd. Date signed 4/18/48

VS 150

662403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 662403

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Anne Arundel
(c) City or town Severna Park, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse V. Hisel

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Beatrice B. Hisel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1904

8. AGE: Years	Months	Days	If less than one day: hr.	min.
43	3	29		

9. Birthplace Ky.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Eastern Stainless Steel

FATHER — 12. Name	unknown
FATHER — 13. Birthplace	"
MOTHER — 14. Maiden Name	
MOTHER — 15. Birthplace	"

16 (a) Informant Mrs. Beatrice Hisel
(b) Address Severna Pk. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/21/48

(c) Cemetery or crematory Moreland Memy. Pk.
Location Balto Co. Md.

18 (a) Funeral director Wm J. Tichnor & Sons
(b) Address Balto. J. Md. Huntington Williams, Mgr.

19 (a) APR 19 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 18 1948 at M

21. I certify that I took charge of the remains described above, held an autopsy / inspection or inquiry thereon and from the evidence obtained by said autopsy / inspection or inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ✓ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place? (What place?)
(d) Means of injury

23. Signature Earl G. Long M.D.
Medical Examiner
Date signed 19 Apr 48

VS 181

062404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 062404

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 21-5
(b) Street address
(c) Hospital or institution Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 426 S. Fursow St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Walter Fountain~~ Walter F. W. Fountain Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-09-1459

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/17 1948 at 4 ~~P~~ M

4. Sex Male

5. Color or race W

6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife Mildred (nee Klunk)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 16, 1901

8. AGE: Years 47 Months 1 Days 1 If less than one day hr min

9. Birthplace Crisfield Md. (Town, county, state)

10. Usual Occupation Chief Clerk - Freight

11. Industry or business B & O. R.R.

12. Name Samuel Fountain

13. Birthplace Ridgely, Md.

14. Maiden Name Mary E. Robertson

15. Birthplace N.C.

16 (a) Informant Mrs. Mildred Fountain

16 (b) Address 426 S. Fursow St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/20/48 (month, day, year)

17 (c) Cemetery or crematory Meadowridge Location Howard Co. Md.

18 (a) Funeral director Wm. J. Pickens & Sons

18 (b) Address Balto. Md.

19 (a) APR 19 1948 (Date received by registrar) Huntington Williams, M.D. (Registrar)

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death Pulmonary Congestion

Due to Old Myocardial degeneration

Due to Lung disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

(f) Signature Stanley Miller

Address Date signed 4/19/48

VS 150

662405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

662405
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 373 MAYDELL RD
(c) Hospital or institution 25-1
(d) Length of stay in hospital or instit. yrs., mos., or days
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
a. State MD b. County
c. City or town BALTIMORE
(If outside city or town limits, write RURAL and give name)
d. Street No. 373 MAYDELL RD - 25
(If rural, give location)
e. Citizen of foreign country? — Yes or No?
If yes, name country

3 (a) FULL NAME JULIA M LANDIS
3 (b) If veteran, name war —
3 c. Social Security Account No.
4. Sex F
5. Color or race W
6 a. Single, married, widowed or divorced DIVORCED
6 b. Name of husband or wife WM O ROMISER
6 c. If alive, give age years
7. Birth date of deceased mo. day yr. 3/16/1874
8. AGE: Years 74 Months 3 Days 1 If less than one day hr. min.
9. Birthplace PA
(State, county and town)
10. Usual Occupation
11. Industry or business

PATIENT
12. Name WM H LANDIS
13. Birthplace PA.

INFORMANT
14. Maiden Name MARY EICHMAN
15. Birthplace PA.
16 a. Informant MRS CHARLES KNIGHT
b. Address

17 a. BURIAL (Date interred) 4/20/48
(Burial, cremation or removal)
c. Cemetery or crematory FAIRFIELD
Location BALTO Co MD
18 a. Funeral director H. M. TICHENOR & SON
b. Address BALTO MD
19 (a) APR 20 1948 (Date received by registrar) Catherine Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/17 1948 at [illegible]
21. I hereby attest that death occurred on the date above stated, that I attended the deceased from [illegible] and that I last saw h[illegible] on [illegible] 1948
Immediate cause of death
Pulmonary thrombosis 10 Days.
Due to Generalized atheromatosis
Antecedent causes Morbid conditions if any giving rise to immediate cause (a), (b), (c) in order last stage
Disease with contributed but not related to cause given in (a) Hypertension and by auscultation
Other Conditions

PHYSICIAN
Underline the cause to which death should be charged under these heads

Operation (Include operations within 4 weeks of death)
Date of operation
Major findings of operation
Autopsy

22. If death was due to external causes (fill in the following)
a. Accident, suicide or homicide
b. Date of occurrence
c. Where did injury occur?
d. Did injury occur in or about home, on farm, industrial place, in public place?
Manner of injury
How injury occurred
Signature Wm Michel
Address 90. Edmondson Ave

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry of "Unknown" or failure to furnish items of information known or readily supplied will cause delay in issuance of permit. Be sure that you have answered correctly and completely. Please give full name of deceased, not initials. Be sure that you have given correct age in especially important. Physicians: please write the cause of death clearly and legibly.

D-46-61990

062406

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

062406

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH
a. Baltimore City, Maryland
b. Street address 511 Division St
c. Hospital or institution Provident Hospital
d. Length of stay in hospital or institution of death 4 Mins
e. Length of stay in Baltimore city limits at time of death 5 Months 1 Fe

2. USUAL RESIDENCE OF DECEASED
a. State MD
b. County
c. City or town Baltimore
d. Street No. 1605 W. Lexington St
e. Citizen of foreign country? No
If yes, name country None

3. a. FULL NAME Stanley Carroll
3. b. If veteran, name war
3. c. Social Security Account

4. Sex Male
5. Color or race Negro
6. Single, married, widowed, or divorced

6. a. Name of husband or wife
6. b. If alive, age, years

7. Birth date of deceased (mo., day, yr.) 1/17/48
8. AGE: Years 3 Months Days If less than 1 day, hrs. or min.
9. Birthplace Baltimore, MD (Town, county, and state)
10. Usual Occupation None
11. Industry or business
12. Name of father Robert Scott
13. Birthplace of father South Carolina
14. Maiden name of mother Ellen Carroll
15. Birthplace of mother Va
16. a. Informant Ellen Carroll
b. Address 1603 West Lexington St
17. a. Burial, cremation, or removal Burial b. Date thereof April 1951
c. Cemetery or crematory Mount Auburn
Location Pikesville Md
18. a. Funeral director Harry H. Young
b. Address 616 N. Howard St
19. April 18 1951 Interington Williamsville

MEDICAL CERTIFICATION
20. DATE OF DEATH 4/13/51 3Y-3M
21. I hereby attest that death occurred on the date above stated, that I attended the deceased from 4/13/51 to 4/13/51, and that I last saw the deceased alive on 4/13/51

Immediate cause of death
Lobar Pneumonia
Due to
Due to
Other Conditions

Autopsy?

PHYSICIAN
Underline the cause to which death should be charged under these rules

Duration of employment within 1 months of death
Date of operation
Major findings of operation

22. If death was due to external causes, fill in the following:
a. Accident, suicide or homicide
b. Date of occurrence
c. Where did injury occur?
d. Did injury occur about home, on farm, industrial place or public place?
e. Nature of injury
23. Signature W. Gamers
Address 511 Division St Date signed 4/17/51

VS 100

Haviland

BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. G62107

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 Robert St.
(c) Hospital or institution 14-2
(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore yrs. mos. or days

2. USUAL RESIDENCE OF DECEASED:
a. State Md. b. County
c. City or town Baltimore (If outside city or town, name RURAL and give town)
d. Street No. 506 Robert St (If none, give location)
e. Citizen of foreign country? Yes or No?
If yes, name country Turkey

3. (a) FULL NAME Edith O. Tucker
(b) If veteran, name war: (c) Social Security Account No.
4. Sex: Female 5. Color or race: Colored 6. (a) Single, married, widowed, or divorced: Widow
6. (b) Name of husband or wife: Tucker
6. (c) If alive, give age: years
7. Birth date of deceased: mo. June day 21 yr 1875
8. AGE: Years 62 Months Days If less than one day: hr. min.
9. Birthplace: Cowings Mills, Md. (Town, county and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Thomas Thornton
13. Birthplace: Balto. Co. Md

MOTHER
14. Maiden Name: Laura F. Johnson
15. Birthplace: Balto. Md

16. (a) Informant: Randolph Tucker
(b) Address: 506 Robert St.
17. (a) Buried (Burial, cremation, or removal) (b) Date thereof: 4-19-48 (month) (day) (year)
(c) Cemetery or crematory: Pleasant Hill
Location: Baltimore Co. Md.
18. (a) Funeral director: Mrs. Lawyer H. Holland
(b) Address: 1631 Druid Hill Ave.
19. (a) (Date received by registrar) (b)

APR 19 1948

Huntington Williams Monthly

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1948 at 7 P M
21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1948 to April 15 1948; and that I last saw deceased alive on April 15 1948
Immediate cause of death: Coronary Thrombosis — Duration: 1
Due to:
Due to:
Other Conditions: Myocarditis
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:
23. Signature: [illegible] M. D.
Address 361 Dolphin Date signed 4-19-48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G62408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12la

G62408 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2110 N. Howard St.
(c) Hospital or institution: 12-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2110 N. Howard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hattie Backus

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex F | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Daniel Backus

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1. 1893

8. AGE: Years 54 | Months 7 | Days 17 | If less than one day hr. min.

9. Birthplace Balto. Co. Md. (Town, county, and state)

10. Usual Occupation domestic

11. Industry or business

FATHER
12. Name Samuel Perwines
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Mary Jones
15. Birthplace Balto. Co. Md.

16 (a) Informant Catherine Wilson Lindsay
(b) Address Texas, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/48 (month) (day) (year)
(c) Cemetery or crematory Lootes Hill
Location Cockeysville, Md.

18 (a) Funeral director William S. Chatman Jr
(b) Address 1701 McCulloh St.

19 (a) APR 19 1948 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1948 at 1530 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947 to Apr 18 1948 and that I last saw h[illegible] alive on April 17 1948.

Immediate cause of death Cardiac Renal Disease — Duration 8 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]

Address 2329 Guilford Ave Date signed Apr 19, 1948

C62409

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 195E

C62409 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 16-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 911 W. Stricker St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Larkins (Jim Henry Larkins SMT)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Dorothy Larkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 3/21/1914
8. AGE: Years 34 SMT | Months | Days 7 | If less than one day: hr. min.

9. Birthplace Currie N. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Bruce Larkins
13. Birthplace Currie N. C.

MOTHER
14. Maiden Name Mary E. Thompson
15. Birthplace Atkinson N. C.

16 (a) Informant Dorothy Larkins
(b) Address 911 W. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 20 1948 (month) (day) (year)
(c) Cemetery or crematory Burgaw, N C.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St Huntington Williams Mgr

19 (a) (Date rec'd by Local Reg.) APR 19 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 April 1948, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to h[illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull - inter cranial hemorrhage
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 17 Apr. at 12 30 P. M. 25/6
(b) Where did injury occur? Md. Drydock Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury. Fell striking against object

23. Signature [illegible] M.D. Medical Examiner
Date signed 19 April 48

X

G62410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

G62410 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 715 Ramsay St
(c) Hospital or institution: 21-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) –
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 715 Ramsay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Conroy

3 (b) If veteran, name war –
3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Thomas P.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 18th 1867

8. AGE: Years	Months	Days	If less than one day
80	6	29	hr. min.

9. Birthplace Lancaster So. Carolina
(Town, county, and state)
10. Usual Occupation House Work
11. Industry or business at Home

FATHER
12. Name Charles L. Wilson
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Margaret Brewer
15. Birthplace Lancaster So. Carolina

16 (a) Informant Charles L. Conroy
(b) Address 715 Ramsay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/20/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Cowan Wilson
(b) Address 2903 Hollins St.

APR 19 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16th 1948. 10:30 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/13/ 1948 to 4-16 1948.
and that I last saw h[illegible] alive on 4-16 1948.

Immediate cause of death: Acute Cardiac Collapse — Duration 1 da

Due to Carcinoma of Bladder & Metastases — 6 mos

Due to Hypertrophy Arteriosclerosis Cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
Autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joseph G. Lancaster
Address 2903 Washington Blvd Date signed 4-17-48

VS 150

G62411 BALTIMORE CITY HEALTH DEPARTMENT G62411

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 223 N. Fulton St.
(c) Hospital or institution: 19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 223 N. Fulton Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Anna Cecelia Mc Gee

3 (b) If veteran, name war
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife (deceased) John Joseph McGee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1885

8. AGE: Years	Months	Days	If less than one day: hr.	min.
62	4	24		

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Frank McDevitt
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Kane
15. Birthplace Ireland

16 (a) Informant Mrs John Cornelius
(b) Address 4313 Flowerton Rd.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem. Location 4300 Old Frederick Rd
18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins St
19 (a) (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1948, at 10 A. M.
21. I certify that death occurred on the date above stated; that I attended deceased from March 21 1948 to April 15 1948; and that I last saw her alive on April 15 1948.

Immediate cause of death Heart Block (about 24) — Duration 1 week

Due to Cardiosclerosis

Due to Age.

Other Conditions Influenzal (grippe) 1 month ago, which provoked no medical attention

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Charles A. Pappo II
Address 2812 Greenmount Ave. Date signed 4/22/48

APR 23 1948
Huntington W. Va. Registrar

US 150

GR. C62112 118294

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH V. 13B

Registered No. C62112

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 20 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town Essex MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Bayne Ave. And Back River RD. Essex
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Upton

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	sep.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 28- 1913

8. AGE: Years	Months	Days	If less than one day
35	1	9	hr. min.

9. Birthplace Texas
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Minter
13. Birthplace Texas

MOTHER
14. Maiden Name Lucinda ?
15. Birthplace Texas

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave April 8- 1948

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Beaumont
Location Texas

18 (a) Funeral director Robert Williams
(b) Address 515 McElderry St

19 (a) 4-9 1948 (b) Huntington Williams
(Local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 9 - 1948 . at 11.00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-19-1948 to 4-9-1948, and that I last saw her alive on 4-9-1948.

Immediate cause of death
Bilat. Far advanced Pulmonary TBc — Duration 2 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Nil
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John B. Mannon
Address Balto. City Hosp. Date signed 4/13/48

VS 150

X

C62413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

C62413
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2523 Hurley Ave
(c) Hospital or institution: 15-17 ✓

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2523 Hurley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Glaser

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	Married

6 (b) Name of husband or wife Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
57				

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Grocer
11. Industry or business

FATHER
12. Name Jacob
13. Birthplace Russia

MOTHER
14. Maiden Name Hannah
15. Birthplace Russia

16 (a) Informant Ida Glaser
(b) Address 2523 Hurley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-20-48 (month) (day) (year)
(c) Cemetery or crematory Beth Israel
Location Southern Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 210 Eutaw Place

19 4-18 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 – 17 – 1948 at 2:39 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1940 to 4/18 1948 and that I last saw h[im] alive on April 18, 1948.

Immediate cause of death Coronary thrombosis — Duration: 3 days
Due to Coronary artery disease — 4 years
Due to Arterio-sclerosis — 10 years
Diabetes mellitus — 6 mos.
Other Conditions Hemiplegia (1944) Coronary thrombosis (1945)
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(e) Means of injury

23. Signature Paul Cohen
Address 1804 Eutaw Place Date signed 4/19/48

VS 190

G62414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G62414 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1631 E. Monument

(c) Hospital or institution: ✓ 7.5

(d) Length of stay in hospital or inst. (yrs., mos., days)

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:

a. State Md b. County

c. City or town Baltimore Md

If outside city or town limits, write RURAL and give town

d. Street No. 1631 E. Monument St

(If rural give location)

e. Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Emma Kennard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced widow

6 (b) Name of husband or wife Richard Kennard

6 (c) If widow, give age of husband

7. Birth date of deceased (mo., day, yr.) July 6, 1866

8. AGE: Years 81 Months 9 Days 10 If less than one day hr. min.

9. Birthplace Caroline Co Va (Town, county and state)

10. Usual Occupation None

11. Industry or business

12. Name of father William Woodyard

13. Birthplace Caroline Co Va

14. Maiden name of mother Louisa Thatcher

15. Birthplace Va

16 (a) Interment Emma Kennard

(b) Address 1631 E. Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date of [illegible]

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Grover C Wilson

(b) Address 1001 Brantly Ave

19 1948 Funeral by registered Thurlington Williams MD Signature

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1948 at 9 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Dec 22 47 to Apr 14 1948 and that I last saw h alive on Apr 14 1948

Immediate cause of death Cerebral Hemorrhage

Due to Arterio Sclerosis

Due to

Other Conditions

(Contributing circumstances within 1 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes (Fill in the following)

(a) Accident, suicide or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur while deceased was in home, industrial place, or public place? While at work?

(e) Manner of injury

(f) Nature of injury

PHYSICIAN

Underline the cause to which death should be charged under each

Edward Dicker

1629 E Monument Date Apr 17 1948

98 100

62415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

62415

Registered No.

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address 1100 W
(c) Hospital or institution Provident Hospital
(d) Length of stay in hospital or inst. (yrs. mos. or days) 1 year
(e) Length of stay in Baltimore (yrs. mos. or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED
(a) State Md.
(b) City or town Baltimore
(c) Street No. 814 N. Caroline St.
(d) Citizen of (country) Yes or No
If yes, native or naturalized

3 (a) FULL NAME Frank Hill

(b) If veteran, exact war

(c) Social Security No.

4. Sex M
5. Color or race C
6. (a) Single, married, widowed or divorced S
(b) Name of husband or wife
(c) If widow, give age

7. Birth date of deceased (mo. day and yr.) March 29-1929
8. AGE Years 19 Months 18 Days
9. Birthplace Chester S. C.
10. Usual Occupation Labor
11. Industry or business
12. Name Frank McCray
13. Birthplace Saulsbury N. C.
14. Maiden Name Claudie Pride
15. Birthplace Chester S. C.
16. (a) Informant Claudie Pryce
(b) Address 814 N. Caroline St
17. (a) Burial (Burial, cremation or removal) April 19 48
(b) Cemetery or crematory Mt. Calvary and Brooklyn Md.
Location
18. (a) Funeral director Elroy C. Wilson
(b) Address 1000 Chantry ave

Apr 19 1948

VS 10:

MEDICAL CERTIFICATION

19. DATE OF DEATH April 19 48 5:15 P.M.

20. I saw deceased from April 1 to April 19 1948, and last saw deceased alive on April 19 1948. Cause of death was ascertained by Autopsy. Disease was first diagnosed by me on April 19 1948. Symptoms first noted March 1948. To the best of my knowledge death occurred on the date stated above, at 5:15 P.M., and the cause of death was as follows:

IMMEDIATE CAUSE OF DEATH Edema of Pneumonia of both lungs, following bronchial Pneumonia

Other contributory causes Tuberculosis of all caseous of the lungs

22. If accident, suicide or homicide, state when, where and how injury occurred, and whether while at work

(a) Date of injury M.
(b) Where injury occurred
(c) Was injury work connected? Was it in public place?
(d) Manner of injury
(e) Nature of injury

Signature Geo. L. Wagner for Theodore Gladden M.D.
Date signed April 19 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Medical certificate must be completed, signed and dated by the person who certifies the cause of death promptly and legibly.

Dr Register C

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

662316
Registered No.

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address 437 N Carrollton Ave
(c) Hospital or institution

(d) Length of stay in hospital or other institution, if any, before death
(e) Length of stay in Baltimore, if any, before death 20 Yrs

2. RESIDENCE OF DECEASED
(a) State Md
(b) City or town Baltimore
(c) Street address 437 N. Carrollton Ave
(d) Ward

3. (a) FULL NAME Thomas Smith

(b) If married, widow, or widower

(c) Social Security Number

4. Sex Male
5. Color or race Col.
6. (a) Single, married, widowed, or divorced Single
(b) Name of husband or wife
(c) If widow, give maiden name

7. Birth date of deceased (month, day, and year) 4-22-1865
8. AGE Years 79 Months Days If less than one day, hours or minutes
9. Birthplace Baltimore
Town, county, and state

10. Usual Occupation
11. Industry or business

INFORMANT
12. Name Manuel Smith.
13. Birthplace Towson md

BURIAL
14. Maiden Name workmen
15. Birthplace workmen

16. (a) Informant Mary Smith
(b) Address 437 N. Carrollton Ave
17. (a) Burial (Date thereof) 4-21-25
Burial, cremation, or removal
(b) Cemetery or crematory Mt Calvary Cem.
Location Baltimore md
18. (a) Funeral director Chas O Wilson
(b) Address 1 [illegible] Baltimore

19. Filed 4-20-1925
Registrar

20. MEDICAL CERTIFICATION
I hereby certify that I attended the deceased from 4-13 1925 to 4-19 1925
and that I last saw the deceased on 4-15 1925
Immediate cause of death
a Acute Lobar Pneumonia
Due to Hypostatic congestion
Due to
Other Conditions

Duration
a 3 days
b

PHYSICIAN
Underline the cause to which death should be assigned under usually

Date of operation
Major findings of operation

21. If death was due to an external cause, fill in the following
(a) Accident, suicide or homicide
(b) Date of occurrence
(c) Where did occurrence occur?
(d) Did injury occur while deceased was engaged in any occupational pursuit or in public place?
(e) Nature of injury

22. Signature G. C. Sewell
Address 124 Aisquith
Date signed 4-19-25

23. Registrar

De Bellevue 662117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1-2a

662117

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 705 Greenmount ave

(c) Hospital or institution 10-2

(d) Length of stay in hospital or inst. (yrs., mos. or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs

2. USUAL RESIDENCE OF DECEASED:

a. State Md b. County

c. City or town Baltimore

(If outside city limits, write RURAL and give town)

d. Street No. 705 Greenmount ave

(If rural give location)

e. Citizen of foreign country? Yes or No?

If yes, name country

3 (a) FULL NAME Minnie Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col.

6 a) Single, married, widowed or divorced Widow

6 (b) Name of husband or wife

6 c) If alive, give age years

7. Birth date of deceased mo. day yr. 7-7-1882

8. AGE: Years 65 Months Days If less than one day hr. min.

9. Birthplace Willmington N. C.

(Town, county and state)

10. Usual Occupation —

11. Industry or business

FATHER

12. Name Unknown

13. Birthplace Unknown

MOTHER

14. Maiden Name Ruth P.

15. Birthplace Unknown

16 (a) Informant Annie Mc Duffy

b. Address 705 Greenmount ave

17 a. Burial (Burial, cremation, or removal) b. Date thereof April 2 - 48 (month) (day) (year)

c. Cemetery or crematory West Southern Line

Location Southern Pines N. C.

18 (a) Funeral director Elroy S. Wilson

(b) Address 1009 Brantly ave

19 (a) (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1948 at 4.55 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 7-15 1945 to 4-19 1948 and that I last saw h Sf alive on April 16 1948.

Immediate cause of death: Myocardial degeneration — Duration 1 hr.

Due to Cardiorenal disease — 5 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

a. Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

d. Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify)

e. Means of injury

23. Signature a. e. Burwell

Address 171 Augusta Date signed 4-19-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

C62118 Registered No.

C62118

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1707 Ashburton St
(c) Hospital or institution: 15.6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 Ashburton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Catherine Garner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Addison P. Garner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 20 1861

8. AGE: Years	Months	Days	If less than one day
86	11 10	29	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business at home.

FATHER
12. Name Frank Lokey
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Hukenson
15. Birthplace Pennsylvania

16 (a) Informant Telford E. Garner
(b) Address 1707 Ashburton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 21 48 (month) (day) (year)
(c) Cemetery or crematory Irvington Baptist
Location Irvington Md

18 (a) Funeral director Harry N. Lennarson
(b) Address 4204 Edgewood Ave

19 (a) Date rec'd by registrar Apr 19 1948 (b) Registrar's signature Hunterton Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1948, at 11:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 47 to April 18 1948, and that I last saw h alive on April 8 1948.

Immediate cause of death
Coronary thrombosis — Duration 2 days
Due to Arteriosclerotic cardiovascular disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert J. Shaket M. D.
Address 2201 Edmondson Ave Date signed 4-19-48

VS 150

C62119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

C62119 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3704 W Belvedere ave
(c) Hospital or institution: 27-18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 3704 W Belvedere ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** George H Wagner

3 (b) If veteran, name war: V | 3 (c) Social Security Account No.: C

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife: Rebecca A Stafford
6 (c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.) Oct 18-1860

8. AGE: Years	Months	Days	If less than one day: hr.	min.
87	6	1		

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Ret farmer
11. Industry or business

FATHER — 12. Name	George Wagner
13. Birthplace	Md
MOTHER — 14. Maiden Name	Lydia A Albert
15. Birthplace	Md

16 (a) Informant Mrs Rebecca Wagner
(b) Address 3704 W Belvedere ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 21/48 (month) (day) (year)
(c) Cemetery or crematory Wesley
Location Carroll co Md
18 (a) Funeral director Edw Tipton
(b) Address Hampstead Md
19 (a) [illegible] (b) Date received by registrar [illegible]

MEDICAL CERTIFICATION

20. **DATE OF DEATH** April 19th 1948, at 5.55 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from May 27 1945 to April 19th 1948, and that I last saw h alive on April 17th 1948.

Immediate cause of death: Chronic Myocarditis — Duration 6 mos.
Due to: Art. Sclerosis — 5 yrs.
Due to:
Other Conditions: Hypertension — 5 yrs.
Cerebral Hemorrhage — 1948
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature James A. Miller M.D.
Address Pikesville, Md Date signed 7/19/48

VS 150

C62420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9-7

Registered No. C62420

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1302 W. Lexington St

(c) Hospital or institution: Home of Our Lady

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 9 days.

(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 378 Forrest St. Balto. (If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME: Nellie Mincher (NELLIE M. MINCHER)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6. (a) Single, married, widowed or divorced	6 (b) Name of husband	6 (c) If alive, give age
Female	White	Widow	John F. Mincher	years

7. Birth date of deceased mo., day, yr Dec 20 1876

8. AGE: Years	Months	Days	If less than one day: hr	min
71	3	29		

9. Birthplace (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER — 12. Name	Theodore Reinheimer
FATHER — 13. Birthplace	V
MOTHER — 14. Maiden Name	Barbara Pinkney
MOTHER — 15. Birthplace	V

16 (a) Informant Walter A. Byrd

(b) Address 378 Forrest st.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/22/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ London Park

Location Balto. Md.

18 (a) Funeral director Williams Cook Inc.

(b) Address 127 St. Paul St.

19 (a) APR 20 1948 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1948, at 7.35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1948, to April 18 1948, and that I last saw h-r alive on April 18 1948.

Immediate cause of death: Acute Cerebral Embolism — Duration: 1 day

Due to Cardio-vascular Lues

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Harry Klineman M.D.

Address 3[illegible] W. Fayette St Date signed April 19 1948

G62421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G62421

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3360 Hickory Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 d

(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3360 Hickory Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte Moszner

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4 Sex Female

5 (a) Color or race White

5 (b) Single, married, widowed, or divorced Widow

6 (a) Name of husband or wife Charles

6 (b) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 24, 1862

8. AGE. Years 85 Months 3 Days 23 If less than one day Hrs. 24 min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Ferdinand Landauer

13. Birthplace Germany

MOTHER 14. Maiden Name Christine (Unknown)

15. Birthplace Germany

16 (a) Informant Elmer L. Moszner

(b) Address 3360 Hickory Ave

17 (a) Final disposition Burial (Burial, cremation, or removal)

(b) Date thereof 4/20/48 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.

Location Baltimore Md

18 (a) Funeral director Wilson & Son

(b) Address 1217 St Paul St

APR 20 1948
(Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1948 at 7:20 M

21. I certify that death occurred on the date above stated, that I attended deceased from April 12, 1948 to April 17, 1948 and that I last saw — alive on April 17, 1948

Immediate cause of death: Cardiac Failure. — Duration: 7 days

Due to: Chronic Myocarditis — Duration: Unknown.

Due to:

Other Conditions: Hypertension. — Duration: Unknown

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank M. Cohen M.D.

Address 2701 N. Calvert St. Date signed April 17 '48

VS (5)

G62422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 937

Registered No. G62422

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St.
(c) Hospital or institution: Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-2-10da
(e) Length of stay in Baltimore (yrs., mos., or days) 22-2-10da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Queen Annes
(c) City or town Kent Island
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emily Ann Goodhand
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2 - 1876

8. AGE: Years	Months	Days	If less than one day
72	8	16	hr. min.

9. Birthplace Kent Island - Md.
(Town, county, and state)
10. Usual Occupation nurse
11. Industry or business

FATHER
12. Name William Walter K. Goodhand
13. Birthplace Kent Island, Md

MOTHER
14. Maiden Name Sarah E. White
15. Birthplace Kent Island - Md

16 (a) Informant Laura E. Fischer Night Supt.
(b) Address 700 W. 40th - Home for Incurables

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-21-48 (month) (day) (year)
(c) Cemetery or crematory STEVENSVILLE CEM
Location STEVENSVILLE MD

18 (a) Funeral director Mrs Chas A. J. Rohde
(b) Address 2317 Edmondson Ave

19 (a) APR 20 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 18 - 1948 at 3 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 8 - 1948 to April 18 1948, and that I last saw her alive on April 16 - 1948.

	Duration
Immediate cause of death: Cerebral Hemorrhage	2 hours ?
Due to: Hypertensive Cardio Vascular Disease	10 years ?
Due to	
Other Conditions: Parkinson's Disease	3 years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Conrad Wolf M.D.
Address 11 E. Chase St. Baltimore 2 Date signed 4/18/48

G62423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

G62423 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1215 Light St.
(c) Hospital or institution: So. Balto Gen Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Carney (If outside city or town limits, write RURAL and give town)
(d) Street No. East Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Schaffer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife: William H. Schaffer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-23-85

8. AGE: Years	Months	Days	If less than one day
62	5	27	hr. min.

9. Birthplace Penna (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name John Harple
13. Birthplace Md

MOTHER
14. Maiden Name Catherine Rogers
15. Birthplace Balto Md

16 (a) Informant Husband
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Langdon Funeral Home
(b) Address 4401 Belair Rd.

APR 20 1948 (Date rec'd by Registrar) (b) Signature for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-19-1948 at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-2-1948 to 4-19-1948 and that I last saw her alive on 4-19-1948.

Immediate cause of death Pulmonary Embolism — Duration

Due to Thrombophlebitis

Due to multiple embolism

Other Conditions Rheumatic mitral stenosis. (Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William B Cooper Jr. M.D.
Address South Balto Gen. Date signed 4/19/48

VS 150

100R

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G62424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

Registration No. G62424

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [illegible] Maryland.
(c) Hospital or institution: 137
(d) Length of stay in hospital or inst. (yrs., mos., or days
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State [illegible] (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Yes or No)
If yes, name country

3 (a) FULL NAME [illegible]

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M		

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr.

8. AGE: Years	Months	Days	If less than one day hr.	min
7	1	0		

9. Birthplace Barbados, B. W. I.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13 Birthplace

MOTHER
14. Maiden Name ?
15 Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory
Location Arbutus, Maryland

18 (a) Funeral director Charles L.
(b) Address [illegible] Baltimore Avenue

APR 20 1948 Washington Williams M.F.
(Date rec'd by registrar) (Registrar)

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH [illegible] 19[illegible], at [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-14- 1948 to 4-17 1948
and that I last saw him alive on 4-17- 1948.

Immediate cause of death	Duration
Cardiac + Respiratory failure	
Due to Pulmonary Tuberculosis	3-4 yrs.
Due to Uremic Intoxication	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature [illegible]
Address 2340 Madison Ave. Date signed 4-19-48 M D

X

G62425

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

Registered No. G62425

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 711
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 dys
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 326 N. Calhoun Street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME JOHN HARVEY WYNN

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-12-8454

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Married

6 (b) Name of husband or wife Inez F. S. Wynn
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Dec 2, 1902

8. AGE: Years 41 | Months 5 | Days 17 | If less than one day: hr min

9. Birthplace Dudley, North Carolina (Town, county and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Thomas Wynn
13. Birthplace N.C.

MOTHER
14. Maiden Name Della Jacobs
15. Birthplace N.C.

16 (a) Informant Inez S. Wynn
(b) Address 326 N. Calhoun Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 21, 1948 (month) (day) (year)

(c) Cemetery or crematory
Location Mt Olive, N.C.

18 (a) Funeral director Charles R. Low
(b) Address 802 Madison Ave

19 (a) APR 20 1948 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18, 1948, at 5 7/4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 April 1948 to 15 April 1948 and that I last saw him alive on 18 April 1948.

Immediate cause of death: Lobar pneumonia, Left Lower — Duration: 8 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James E. Carr M.D.
Address 515 Mosher St Date signed 4-19-48.

G62426 Bal 5

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 45 F

G62426 Registered No. 38258

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore Co
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 Doolittle Rd (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country .....

3 (a) FULL NAME Herbert Carlton
3 (b) If veteran, name war .....
3 (c) Social Security Account No. 457-14-5365

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Sylvia
6 (c) If alive, give age ..... years

7. Birth date of deceased: mo., day, yr. 7-13-84

8. AGE: Years 63 | Months | Days | If less than one day: hr. | min.

9. Birthplace Tenn (Town, county, and state)

10. Usual Occupation Elec. Engineer
11. Industry or business

FATHER 12. Name John Carlton
13. Birthplace Tenn

MOTHER 14. Maiden Name Agnes Culbertson
15. Birthplace Tenn

16 (a) Informant .....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 20/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Balto
Location .....

18 (a) Funeral director Welch Funeral Home
(b) Address 2008 Orleans St

19 APR 20 1948 (Date rec'd by Registrar) (b) [illegible]

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-16 1948, at 5:30 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 2-7-1948 to 4-16 1948, and that I last saw him alive on 4-16 1948.

Immediate cause of death: Sepsis — Duration: 1 da.
Due to: Operation for — Duration: 12 mo.
Due to: Carcinoma of tonsil
Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation 4-1-48
Major findings of operation: .....
Findings of autopsy: abscess, pterygoid fossa

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury .....

23. Signature Andrew G. Morrow M. D.
Address 714 N Date signed 4-16-48

G62427

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G62427
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 22-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 208 S. Eutaw Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barnard Amelong

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-03-1827

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10th 1898

8. AGE: Years 49 | Months 7 | Days 8 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Rigger

11. Industry or business

FATHER
12. Name Frederick Amelong
13. Birthplace Baltimore

MOTHER
14. Maiden Name Barbara Schuster
15. Birthplace Balto

16 (a) Informant: Dorothy Kwiatkowski
(b) Address 1520 Fleet Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/48
(c) Cemetery or crematory Holy Redeemer
Location Ulleth Edgewood Home

18 (a) Funeral director Todt Orleans St.
(b) Address

APR 20 1948 (Local Registrar) RECEIVED APR 21 1948 Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1948, at 5:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (Specify)
(d) Means of injury

25. Signature [illegible] M.D.
Medical Examiner.
Date signed 19 April 48

G62428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G62428 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2328 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2328 Madison Av. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emory White

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. April 28, 1861

8. AGE: Years 86 | Months | Days 19 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John White
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Bertha Ringgold
(b) Address 1513 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-21-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 APR 20 1948 (Date rec'd by registrar) Huntington Williams, M.D.

VS 153

MEDICAL CERTIFICATION P

20. DATE OF DEATH April 17, 1948 at 6:30 M

21. I certify that death occurred on the date above stated, that I attended deceased from 4-1- 1948 to 4-17- 1948, and that I last saw h(er) alive on 4-17- 1948

Immediate cause of death	Duration
Cardiac + Respiratory failure	
Due to Cerebral Embolism + Paralysis	2 weeks
Due to Hypertension arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis F. Harmon M.D.
Address 2340 Madison Av Date signed 4-19-48

GC2429 JL - 118937

BALTIMORE CITY HEALTH DEPARTMENT — Registered No. GC2429

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNPADDING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 10-2
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 928 E. Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bessie Stokes

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife Willie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. ? 1893

8. AGE: Years	Months	Days	If less than one day: hr.	min.
54 ?				

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Isaac Bryaum (D)
13. Birthplace N. C.

MOTHER
14. Maiden Name Margaret ? (D)
15. Birthplace N. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary. Location
18 (a) Funeral director A. Hulstead
(b) Address 918 E. Druid Hill Ave.
19 (a) Date received by registrar APR 20 1948 (b) Registrar's signature Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1948. 6 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 1948. to April 15 1948. and that I last saw her alive on April 15 1948.

Immediate cause of death Pneumonia L.L.L. R.L.L. & P.L.L.
Due to organic endet Flaccid Hem. plegia, right
Due to cause unknown
Other Conditions Old sparte hem. paresis, left, cause unknown (Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
P
P

PHYSICIAN

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed 4-16-48

VS 150

C62430 #65718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C62430

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 7-1
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 916 Rutland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Wilson
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Mague
6 (c) If widow, give age, years
7. Birth date of deceased mo., day, yr 2-7-95
8. AGE: Years 53 Months Days If less than one day hr min
9. Birthplace Va - (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER 12. Name Calvin Wilson
13. Birthplace Va -

MOTHER 14. Maiden Name Magie Riches
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 20/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem Park
Location Arbutus Md.

18 (a) Funeral director Mrs. Ruth A. Elliott & Daughter
(b) Address 1129 N. Caroline St.

19 APR 20 1948 (Date rec'd by Registrar) Burial Permit Issued

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH After. 17 1948 at 12 PM 30

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 26 1948 to After. 17 1948 and that I last saw him alive on After 17 1948.

Immediate cause of death Resp. Coll

Due to Bronchial Pneumonia

Due to High BP

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Brosch M. D.
Address A H H Date signed Apr. 48

662431

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1948

662431
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1327 N. Central Ave
(c) Hospital or institution: (1 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1327 N. Central Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Norah McQuaig
3 (b) If veteran, name war
3 (c) Social Security Account No

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Landy
6 (c) If alive, give age years
7. Birth date of deceased mo. day yr March 11, 1900
8. AGE: Years 48 | Months | Days | If less than one day hr min
9. Birthplace Ledgering N. C. (Town, county and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name Gett Bure
13. Birthplace N. C

MOTHER
14. Maiden Name Ella McNeil
15. Birthplace N. C

16 (a) Informant Mattie Smith
(b) Address 1307 N. Central Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 4/20/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem. Location A A County

18 (a) Funeral director Mrs Robt A Elliott & Dgt
(b) Address 1129 N. Carrollton St.

19 (a) Date received by Registrar APR 20 1948 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1948 at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-3- 1948 to 4-16- 1948, and that I last saw her alive on 4-16- 1948.

	Duration
Immediate cause of death: Hypostatic Pneumonia	2 days
Due to: Cerebral Accident	4 days
Due to: Previous cerebral accident	2 mo
Valvulitis	?

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. J. Thiper
Address 422 E. Lord St Date signed 4/19/48

Thiper X

G62432

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1948

G62432 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1229 63rd St
(c) Hospital or institution: 26-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1229 63rd St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Earseman A. Grimm

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Ora B. Grimm
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) June 20, 1865

8. AGE: Years	Months	Days	If less than one day
82	9	20	hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Morgan Grimm
13. Birthplace Ohio

MOTHER
14. Maiden Name — Galloway
15. Birthplace Ohio

16 (a) Informant Mrs. Ora B. Grimm
(b) Address 1229 63rd St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/21/48 (month) (day) (year)
(c) Cemetery or crematory Toronto Cemetery
Location Toronto, Ohio

18 (a) Funeral director Howard N. Bigelow Jr.
(b) Address 4914 Belair Road

19 (a) APR 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1948, at 2:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1948 to April 19 1948 and that I last saw h. alive on April 14 1948.

Immediate cause of death: Coronary occlusion — Duration: Sudden
Due to Latent Syphilis
Cardio-Vascular disease typ.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Baumgardner M. D.
Address Balto 6 Date signed 4-19-48

C62433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 192 B

Registered No. C62433

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 255 St. Helena Ave (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Eva C. Guntner (EVA C. GUNTNER)

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-01-3182

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph G.

6 (c) If alive, give age: 33 years

7. Birth date of deceased mo., day, yr: 9-20-16

8. AGE: Years 31 | Months 6 | Days 28 | If less than one day: hr ..... min .....

9. Birthplace: Baltimore, Md (Town, county, and state)

10. Usual Occupation: House-Work.

11. Industry or business: At Home

FATHER
12. Name: Joseph Krupkowski
13. Birthplace: Poland

MOTHER
14. Maiden Name: Mary KARMIERCKAZ.
15. Birthplace: Poland

16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4- -48. (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus Cem.
Location Dundalk Ave.

18 (a) Funeral director Charles L. Zeiler
(b) Address 901 S. Conkling St.

APR 20 1948 (Date received by registrar) Huntington Maryland (Registrar)

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18, 1948, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-12- 1948 to 4-16- 1948 and that I last saw her alive on 4-18- 1948.

Immediate cause of death: Cardiac failure

Due to: Acute rheumatic myocarditis

Due to: .....

Other Conditions: Mitral stenosis and insuff.; aur. fibrillation (Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: Positive

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Victor J. McKenrick M.D.
Address 1 E. Pleasant St. Date signed 4/19/48

G62434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G62434 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson Ave
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Washington
(c) City or town Hagerstown (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Colin Reed - Collin McTurnahan Reed

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mary Reed

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Dec 23, 1885

8. AGE: Years 62 | Months 3 | Days 27 | If less than one day hr min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Insurance Solicitor

11. Industry or business

FATHER 12. Name Collin Reed

13. Birthplace Washington Co Md

MOTHER 14. Maiden Name Ida Stockton Ford

15. Birthplace Md

16 (a) Informant Ritchie & Hall

(b) Address Hagerstown Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) Apr 22 1948

(c) Cemetery or crematory Washington Co

Location Washington Co

18 (a) Funeral director Wm. Thos. John H. Tuppan Son

(b) Address 2311 Edmondson Ave

19 APR 20 1948 (Date rec'd by registrar) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-20 1948, at 5:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-1 1948 to 4-20 1948, and that I last saw him alive on 4-20 1948.

Immediate cause of death: Resp Failure — Duration: 4 days

Due to CVA

Due to Coronary Thrombosis

Other Conditions Arthritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R G Mayhugh M.D.

Address Wash. Hosp. Hagerstown Md Date signed 4-20 1948

VS 150

2435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C62435

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 15-4
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1662 West North Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William AVERY William Russell Avery

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: MALE

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mamie Avery

6 (c) If above, give age

7. Birth date of deceased (mo., day, yr.): April 13, 1886

8. AGE: Years: 62 Months: Days: If less than one day: hr. min.

9. Birthplace: Morgantown W.C.

10. Usual Occupation: Dentist

11. Industry or business:

12. Name of Father: Alfred Avery

13. Birthplace: Morgantown W.C.

14. Maiden Name of Mother: Lodtisha Greenle

15. Birthplace: Unknown

16 (a) Informant: Mamie V. Avery

(b) Address: 1662 N. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 20, 1948

(c) Cemetery or crematory: Mt. Calvary

Location: Robert L. Young

18 (a) Funeral director: Robert L. Young

(b) Address: 1216 E. Caroline St.

19 APR 20 1948 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-17-1948 at 9 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes, or accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary Artery Disease
Dilatation of Heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur in home, on farm, industrial place, or public place? (Which, if work)
(d) Means of injury

23 Signature: Thos. E. Merrill M.D. Medical Examiner

Date signed: 4/19/48

VS 191

2436

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution

(d) Length of stay in hospital or inst. yrs. mos. or days
(e) Length of stay in Baltimore yrs. mos. or days

2. USUAL RESIDENCE OF DECEASED:
a. State
b. County
c. City or town
d. Street No.
e. Citizen of foreign country? Yes or No?
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war
3 (c) Social Security Number
No

4. Sex: FEMALE
5. Color or race: White
6 (a) Single, married, widowed, or divorced
6 (b) Name of husband or wife
6 (c) If other, give age
7. Birth date of deceased (mo. day yr.)
8. AGE: Years | Months | Days | If less than one day
9. Birthplace (Town, county and state)
10. Usual Occupation
11. Industry or business

12. Name
13. Birthplace
14. Maiden Name: Marianna Palmowska
15. Birthplace: Poland

16 (a) Informant
(b) Address
17 (a) Burial
(b) Date thereof
(c) Cemetery or crematory
Location
18 (a) Funeral director
(b) Address

APR 20 1948
(Date filed by the registrar)

MEDICAL CERTIFICATION

19. DATE OF DEATH
20. I hereby that deceased on the date above stated that I attended deceased from to and that I last saw alive on

Duration

Immediate cause of death

Due to (or as a consequence of)

Other Conditions

Contributing but not related to cause given

Date of operation
Major findings of operation

PHYSICIAN

Underline the cause to which death should be charged under these rules

21. If death was due to external causes, fill in the following
a. Accident, suicide or homicide
b. Date of occurrence
c. Where did injury occur?
d. Did injury occur while at work?
e. Means of injury
f. Signature
Address
Date signed

662137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 662137

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 22-2 OA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md (b) County
City or town Balto
(If outside of Baltimore City, write R.F.D. and give town)
(d) Street No. 416 Pacca st
(If inside Baltimore)
(e) Citizen of foreign country? Yes or No?
If yes, name country

3 (a) FULL NAME LeRoy Washington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Birdie Washington

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 60 | Months 10 | Days 25 (If less than one day, hrs. or min.)

9. Birthplace Va (Town, county and state)

10. Usual Occupation Coal + ice Dealer

11. Industry or business

FATHER
12. Name Geo Washington
13. Birthplace Va

MOTHER
14. Maiden Name unknown
15. Birthplace Va

16 (a) Informant Susie Porter
(b) Address 416 Pacca st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-22-48
(c) Cemetery Mt. Olivet
Location Balto

18 (a) Funeral director William A Jackson
(b) Address 916 Pacca st

APR 20 1948
(Date rec'd by registrar) Huntington Williams M.D.
(Registrar)

VS 181

MEDICAL CERTIFICATION

19. DATE OF DEATH 4 - 17 - 1948 M.

20. I certify that I took charge of the remains described above, held an inquest thereon and from the evidence obtained at Autopsy (post-mortem examination) or inquiry (and from my own knowledge during the last 365 days before death) I have knowledge that the said deceased came to his death on the day stated above, and death in my opinion resulted from natural causes / accident / suicide / homicide / undetermined and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include conditions which contributed to death)

22. If an external cause was probable or was suspected, causing death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, or at place of public place?
(d) Means of injury

23. Signature Earle Royer M.D.
(Medical Examiner)
Date signed 19 Apr 48

G62438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. G62438

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St.
(c) Hospital or institution: Stone for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
a. State Md. b. County
c. City or town Baltimore (If outside city or town limits, write RURAL and give town)
d. Street No. 1200 Valley St. (If rural give location)
e. Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Tillman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Mo.	W.	S.

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 24, 1874

8. AGE: Years	Months	Days	If less than one day: hr.	min
74	1			

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Nicholas Tillman
13. Birthplace

MOTHER 14. Maiden Name Mathilda Stonebraker
15. Birthplace

16 (a) Informant Stella Sisters of the Poor
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-21-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Location City

18 (a) Funeral director Wiedefeld & Son
(b) Address Greenmount Ave & 22nd (Undertaker) Huntington Avenue Baltimore Md.

APR 20 1948 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1948 at 6:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Apl 1- 1948 to Apl-19- 1948 and that I last saw him alive on Apl-18- 1948

Immediate cause of death	Duration
Edema Lungs	2 days
Due to Chronic Myocarditis	5 yrs
Due to	
Other Conditions Cardiac Asthma	5 mo.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E. North Ave Date signed 4/19/48

662439

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 167

662439
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 25-V
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3014 Seeman Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ulysses Chestnut

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-18-1948, at 7 05 P. M.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE.	Colored	

6 (b) Name of husband or wife Christine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-15-1917

8. AGE: Years	Months	Days	If less than one day: hr.	min.
31				

9. Birthplace Jugoff S.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Richard Chestnut
13. Birthplace South Carolina

MOTHER
14. Maiden Name Lizzie Chestnut
15. Birthplace South Carolina

16 (a) Informant: Christine Chestnut
(b) Address 3018 Seamon St. Cherry Hill

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 4-20-48 (month)
(c) Cemetery or crematory Camden
Location South Carolina

18 (a) Funeral director. Rayner Sanders
(b) Address 1412 E. Preston St

19 APR 20 1948 (Date rec'd by Registrar) Huntington Williams M.D. (Registrar)

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy (Inspection or Inquiry), find that said deceased came to H.L.S. death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Respiratory failure due to sodium pentothal

Due to

Other Conditions Stab wound of left orbit (Include pregnancy within three months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-18-48 at 6 40 P. M.
(b) Where did injury occur? Hospital - (Provident)
(c) Did injury occur at home, on farm, industrial place, in public place? Hosp. (While at work?) No
(d) Means of injury Based on operating table

23. Signature [signature] M.D. (Medical Examiner)
Date signed

X

G62440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1830

Registered No. G62440

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 637 Hord
(c) Hospital or institution: 22-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 637 Hord (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Stokes Stokes

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-7163

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 6. 1891

8. AGE: Years 56 | Months 4 | Days 13 | If less than one day: hr. min.

9. Birthplace Greensboro North Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Lunit Stokes
13. Birthplace Va

MOTHER
14. Maiden Name Lucy Carter
15. Birthplace Va

16 (a) Informant Queen E. Scott
(b) Address 632 Hord Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1946 (month) (day) (year)
(c) Cemetery or crematory Greensboro N. C.
Location Guilford County

18 (a) Funeral director Joseph A. Tildy
(b) Address 6 Walbert Ave Street

APR 20 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1946 at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/17 1946 to 4/19 1946 and that I last saw h[illegible] alive on 4/19 1946

Immediate cause of death: Cerebral hemorrhage — Duration 2 hr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 734 Brown St Date signed 4/19/46

VS 150

C62441

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

C62441 APR 28 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1326 Mount St
(c) Hospital or institution: 15-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1326 Mount St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Phillips

3 (b) If veteran, name war 1917

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colord

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ellen Phillips

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) ? 1891

8. AGE: Years 57 | Months 5/6 | Days | If less than one day: hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant: Ellen Phillips
(b) Address 1326 Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/48 (Month) (day) (year)
(c) Cemetery or crematory: Balto. Nat
Location: Md

18 (a) Funeral director: Geo. W. Kelson
(b) Address: 1303 Pennsylvania Ave Huntington Woodlawn

19 (a) APR 21 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 17 1948, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 7 1948 to Apr 17 1948 and that I last saw him alive on Apr 15 1948.

Immediate cause of death: Cardio Vascular Disease — Duration: 1 yr 2 3 mos

Due to: Broken Compensation

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
Signature: Ewell Cram, Jr.
Address: 1928 Penna Ave Date signed: 4/21/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C62442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

C62442 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13-6
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town, give R.F.D. and name town)
(d) Street No. 3404 Chestnut St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Daniel Bopst.

3 (b) If veteran, name war

3 (c) Social Security Account No. 165-03-2221

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M.

6 (b) Name of husband or wife Katherine C. (Farmer)
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1904

8. AGE: Years	Months	Days	If less than one day: hr	min
43	4	18		

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Sprinkler Fitter
11. Industry or business Sprinkler Co. Inc.

FATHER
12. Name John H. Bopst
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Jane Grielly
15. Birthplace Md.

16 (a) Informant Mrs. Katherine Bopst
(b) Address 3404 Chestnut Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 23, 1948
(c) Cemetery or crematory St. Marys
Location Hampden

18 (a) Funeral director Paul F. Ulmansieth
(b) Address 3615-17 Chestnut Ave

19 (a) April 21, 1948 (Date received by Local Registrar) Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20/1948 at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Intracranial Hemorrhage (subarachnoid)
Petechial hemorrhages of brain
Edema of lungs.
Partial atelectasis of right lung.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 20/48 1:30 P.M.
(b) Where did injury occur? Chestnut & 34th Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Street Intersection (Specify) No
(d) Means of injury Struck by auto.

23. Signature George B. Merrill M.D.
Medical Examiner
Date signed 4/20/48

VS 151

G62443

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G62443

Registered No. 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2065 Druid Park Drive
(c) Hospital or institution: 12-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2065 Druid Park Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse G Haney
3 (b) If veteran, name war —
3 (c) Social Security Account No. 217-07-2613

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married.
6 (b) Name of husband or wife: Flora J. G Haney
6 (c) If dead, give age 59 years
7. Birth date of deceased mo., day, yr. Feb 15, 1881
8. AGE: Years 67 | Months | Days | If less than one day: hr. | min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation Machine Operator.
11. Industry or business Sekine Brush Co.

FATHER
12. Name Jesse G Haney.
13. Birthplace ?

MOTHER
14. Maiden Name Elizabeth Burrows
15. Birthplace

16 (a) Informant Flora J. G Haney
(b) Address 2065 Druid Park Drive.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 21, 1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Balto. County

18 (a) Funeral director Paul E. G Renawitzky
(b) Address 1615-17 Chestnut Ave.

19 (a) APR - 0 1948 (Date rec'd by registrar) (b) Huntington Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1948 at 1:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 13 1948 to April 19 1948 and that I last saw him alive on April 19 1948.

Immediate cause of death: Myocardial Insufficiency — Duration 1 day
Due to Cardio-renal-Vascular Disease — 3 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J M Nelson
Address 617 W 40th St Date signed 4/19/48

C62444 **BALTIMORE CITY HEALTH DEPARTMENT** C62444
CERTIFICATE OF DEATH 197 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1642 E. Fort Ave.
(c) Hospital or institution: 2d-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1642 E. Fort Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** [illegible]
3 (b) If veteran, name war — 3 (c) Social Security Account No.
4. Sex Male — 5. Color or race — 6. (a) Single, married, widowed, or divorced —
6 (b) Name of husband or wife Mary Thomas
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 3, 1864
8. **AGE:** Years 83 Months 7 Days 17 If less than one day hr. min.
9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation [illegible]
11. Industry or business [illegible]
FATHER 12. Name [illegible]
13. Birthplace Ireland
MOTHER 14. Maiden Name Mary Thomas
15. Birthplace Ireland

16 (a) Informant Mrs. Mary C. Thomas
(b) Address 1642 E. Fort Ave.
17 (a) Burial, cremation, or removal Burial (b) Date thereof 4-21-48 (month) (day) (year)
(c) Cemetery or crematory [illegible]
Location [illegible]
18 (a) Funeral director Chas. J. Keller
(b) Address 1501 E. Fort Ave.
19 (a) Apr (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH April 17 1948, at 4 P.M.
21. I certify that death occurred on the date above stated, that I attended deceased from Aug 1947 to April 17 1948 and that I last saw h alive on April 17 1948
Immediate cause of death Hemorrhage Arteriosclerosis
Due to Senility
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:
Duration 2

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Walter Kohn
Address 1026 E. Fort Ave. Date signed 4/20/48

VS 58

BCr 48-02179

(1923-5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 157a (1923-5)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton & Wilkins Ave.

(c) Hospital or institution: St. Agnes Hospital.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-1

(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 3665 Hinkins Rd (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Hartman -

3 (b) If veteran, name war —

3 (c) Social Security Account No —

4. Sex M.

5. Color or race W

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased: mo., day, yr. Jan. 30-1948

8. AGE: Years — Months — Days 3 mo. If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Theodore Hartman

13. Birthplace Md

MOTHER

14. Maiden Name Helen Searbire

15. Birthplace Md.

16. (a) Informant Parents

(b) Address 3665 Hinkins Rd

17. (a) Buried (Burial, cremation, or removal) (b) Date thereof April 30-1948 (Month, day, year)

(c) Cemetery or crematory London Park

Location Baltimore Md

18. (a) Funeral director George L. Schnaal

(b) Address 3101 Eutaw Ave

19. (a) Date received by local registrar 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-20 1948 at 12 40 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-14 1948 to 4-20 1948. and that I last saw him alive on 4-19 1948

Immediate cause of death Congenital Hydrocephalus — Duration

Due to

Due to

Other Conditions Complete cleft palate. (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Congenital Hydrocephalus

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Jose F. Valderas M. D.

Address St. Agnes Hospital Date signed 4-20-48

VS (8)

X

662446 BALTIMORE CITY HEALTH DEPARTMENT 662446
Registered No.

CERTIFICATE OF DEATH 170c

BC-662445

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospl
(d) Length of stay in hospital or inst. yrs., mos., or days 2 D A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County Balto.
(c) City or town Oliver Beach
(If outside city or town limits, write RURAL and give town)
(d) Street No. Chesapeake Rd.
(If rural, give district)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Penfrom Horne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race White

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5. 1946

8. AGE: Years 1 Months 11 Days 1 (If less than one day) hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name J. B. Horne
13. Birthplace N. Carolina

MOTHER
14. Maiden Name Hazel (Manley)
15. Birthplace Canada

16 (a) Informant Mr. J. B. Horne
(b) Address Oliver Beach

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 21-1948 (month)

(c) Cemetery or crematory Sacred Heart
Location O'Donnell Sta Rd.

18 (a) Funeral director John B. Connelly
(b) Address 418 Eastern Ave. Baltimore, Md.

19 (a) (Date received by Registrar) APR 22 1948

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 April 1948 at 3:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fracture of Skull
Intra-Cranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within three months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 17 at 3:20 P.M.
(b) Where did injury occur? Oliver Beach Md.
(c) Did injury occur in house, on farm, industrial place, in public place? Public (Where at work?) No
(d) Means of injury Struck by Truck

23. Signature Ford L. Kerger M.D.
Medical Examiner.
Date signed 4-22-48

VS 181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. CG22447 / 46B

CG22447

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 4-2
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write R.F.D. and give town)
(d) Street No. 513 West Mulberry St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas M. WHITEFORD

3 (b) If veteran, name war

3 (c) Social Security Account No. 205-22-2380

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife MAMIE R. Whiteford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 10, 1877

8. AGE: Years	Months	Days	If less than one day: hr.	min.
70	10	9		

9. Birthplace Harford Co. Md. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Not Known

MOTHER
14. Maiden Name Lizzie Leucy
15. Birthplace Md

16 (a) Informant Mrs. W.B. Norton
(b) Address Boyds Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-21-48 (month, day, year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn Md.

18 (a) Funeral director L. Howard Strong
(b) Address 3207 W. North Ave

19 (a) APR 20 1948 (Registrar) (b) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-19- 1948 at 11 40 A.M.

21. I certify that I took charge of the remains described above, held an Inspection and Exg. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Carcinoma of stomach

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? Where at work?
(d) Means of injury

23. Signature George F. Merrill M.D. Medical Examiner.
Date signed 4/19/48

X

b 62448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 62448 1860

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
(a) Baltimore City, Maryland 26-6
(b) Street address
(c) Hospital or institution: St Josephs Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (or country)
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1401 S. Clinton (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Luigi or Louis Comi

3 (b) If veteran, name war none

3 (c) Social Security Account No. none

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife late Concetta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19 1870

8. AGE: Years 78 | Months | Days 29 | If less than one day hr. min.

9. Birthplace Catanzaro Italy (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Giovanni Comi
13. Birthplace Italy

MOTHER
14. Maiden Name RAFFAELA SANTA
15. Birthplace Italy

16 (a) Informant John Comi (Son)
(b) Address 1401 S. Clinton St.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** April 21/48 (month) (day) (year)

(c) Cemetery Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Vecchia
(b) Address 524 S. Morley St.

19 (a) (Date rec'd by registrar) **(b)** Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-11 1948 at 1 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardio Respiratory Failure

Due to C.V.A. — Hypertension

Other Conditions Laceration Hematoma Left occiput

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following: 26/6

(a) Date of injury 4-11-48 about 1 20 P M.
(b) Where did injury occur? 1401 S. Clinton St
(c) Did injury occur at home, on farm, industrial place, in public place? At Home While at work? No
(d) Means of injury Fell down stairs at Home

23. Signature Robert B. Wiseman M.D. Medical Examiner.

Date signed 4-18-48

VS 181

C62443

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 121a

Registered No. C62443

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5305 Catalpha Road
(c) Hospital or institution: 27-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5305 Catalpha Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stanislaus Frank Hepner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Stella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1876

8. AGE: Years	Months	Days	If less than one day
71	6	26	hr. min.

9. Birthplace Germany---Poland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Martin Hepner
13. Birthplace Poland

MOTHER
14. Maiden Name Elizabeth Borah
15. Birthplace German-Poland

16 (a) Informant Mrs. Stella Hepner
(b) Address 5305 Catalpha Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-21-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, #14

19 (a) APR 20 1948 (Death rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17, 1948 at M

21. I certify that death occurred on the date above stated, that I attended deceased from April 6, 1948 to April 17, 1948 and that I last saw him alive on April 16, 1948

Immediate cause of death: Chronic Myocarditis

Due to: Arteriosclerotic Cardiovascular Renal Disease

Due to:

Other Conditions

Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel F. Wolfe M. D.
Address 1331 E. North ave Date signed 4-19-48

VS 150

X

G62450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G62450

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cator & Wilkins
(c) Hospital or institution: Jenkins Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Allegheny
(c) City or town Cumberland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 New Hampshire Ave
(If rural give location)
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country

3 (a) FULL NAME Wm A. Shoemaker

3 (b) If veteran, name war: W

3 (c) Social Security Account No. 1948

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Hazel Ambrose
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Feb 21, 1892

8. AGE: Years 56 | Months 1 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland
(City, county, and state)

10. Usual Occupation Watchman Retired

11. Industry or business P.R.R.

FATHER
12. Name James Alfred Shoemaker
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary E. Meyers
15. Birthplace Maryland

16 (a) Informant Mary Shoemaker
(b) Address Cumberland

17 (a) Burial, cremation, or removal (b) Date thereof 4/23/37 (month) (day) (year)
(c) Cemetery or crematory Rose Hill
Location Cumberland Md

18 (a) Funeral director Milton Cook
(b) Address 129 Cook St

19 (a) APR 20 1937 (Date rec'd by Registrar) (b) Signature of Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/20 1937 at 1:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1937 to 4/20 1937 and that I last saw h[illegible] alive on 4/13 1937

Immediate cause of death — Cardiac failure - Degeneration
C.V.D. - 90 yrs
Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place) D. W. MINTZER
(e) Means of injury

23. Signature D. W. Mintzer
Address 40 Bayard Date signed 4/20/37

VS 150

G62451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

100 B

Registered No. G62451

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: St. Agnes Hospital
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town 4415 Marmouth Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Charles Rissler

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-03-9923

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Helen M Rissler

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) April 17, 1893

8. AGE: Years 54 | Months 11 | Days 30 29 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation factory work

11. Industry or business Bel Air Bag factory

FATHER
12. Name Charles Rissler
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Hofbinsky
15. Birthplace Germany

16 (a) Informant Helen M. Rissler
(b) Address 4410 Maxwell Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 20 Apr-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director F. B. Wippert & Son
(b) Address 1300 Eutaw Pl. 17.

19 (a) APR 20 1948 (Date rec'd by registrar) (b) Cuttington Mortuary

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16 1948 2:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/27 1948 to 4/16 1948 and that I last saw h[illegible] alive on 4/16 1948.

Immediate cause of death — Duration
Pulmonary embolism (10 days)
Bi lateral thrombophlebitis
Due to (a) Post partum (Septic puerperium)
Due to Retained Septic Placenta
Due to Septic uterus
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 3/27/48
Major findings of operation: Retained Septic Placenta
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D N Murphy M. D.
Address St Agnes Date signed 4/19/48

VS 150

C62452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. C62452

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2217 Penrose Ave
(c) Hospital or institution 20-V
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (Or foreign country)
(b) City or town Baltimore Co'ty (If outside city or town limits, write RURAL and give town)
(c) Street No. 2217 Penrose Ave. (If rural give location)
(d) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Weber

3 (b) If veteran, name war WW I

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Estelle S.

6 (c) If alive, give age 50 years

7. Birth date of deceased mo., day, yr April-20-1892

8. AGE: Years 55 | Months 11 | Days 28 | If less than one day hr min

9. Birthplace Baltimore - Md (Town, county, and state)

10. Usual Occupation PARCEL Post

11. Industry or business U.S. Govt.

FATHER 12. Name Frantz Weber

13. Birthplace Germany

MOTHER 14. Maiden Name Fredericka Knoll

15. Birthplace Germany

16 (a) Informant Estelle S. Weber

(b) Address 2217 Penrose Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Apr. 21/48 (month) (day) (year)

(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director F.R. Wippert & Son

(b) Address 1800 Eutaw Place—17

19 APR 20 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1948 at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 22 1947 to APRIL 18 1948 and that I last saw him alive on APRIL 18 1948.

Immediate cause of death CORONARY THROMBOSIS — Duration 1 HOUR

Due to ARTERIO SCLEROSIS — Duration 2 YRS.

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stuart D. Sunday M. D.
Address 201-E-33rd St. Date signed APR-20 1948

Dr. Sunday

G62453

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 194a

G62453 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4709 Schley Ave
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4709 Schley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Joseph Weber

3 (b) If veteran, name war

3 (c) Social Security Account No 213-14-8164

4. Sex Male | 5. Color or race White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married

6 (b) Name of ~~husband or~~ wife Carrie Weber

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr July 25th 1876

8. AGE: Years 71 | Months 8 | Days 25 | If less than one day hr min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired Street Car Motorman

11. Industry or business Balto. Transit Co

FATHER 12. Name Joseph Weber

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Katherine Meierring

15. Birthplace Balto. Md.

16 (a) Informant Mrs. Carrie Weber

(b) Address 4709 Schley Ave.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4 23, 48 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Location Parkwood Parkville, Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

APR 21 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20th 1948, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/18 1948, to 4/20 1948, and that I last saw him (M) alive on 4/18 1948.

Immediate cause of death Coronary Thrombosis — Duration 2 da.

Due to

Due to

Other Conditions

Operation (Major surgical operations within four weeks of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury

23. Signature Joseph Tookey M.D.

Address 44 Elwood Rd. Date signed 4/21/48

VS 53

G62454

HL 119063 BALTIMORE CITY HEALTH DEPARTMENT G62454

CERTIFICATE OF DEATH 109a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 5 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 Tuxedo St. Z-11 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Benjamin F. McMahan

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Helen
6 (c) If alive, give age years
7. Birth date of deceased mo., day, yr ~~Mar 13, 1903~~ April 13, 1904

8. AGE: Years	Months	Days	If less than one day
~~45~~	1	7	hr. min.

9. Birthplace Ohio. (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Paint

FATHER 12. Name	Willis McMahan
FATHER 13. Birthplace	Penn
MOTHER 14. Maiden Name	Sarah Case
MOTHER 15. Birthplace	Penn.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Avenue
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/21/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Newton
Location Pennsgrove
18 (a) Funeral director William Cook Inc.
(b) Address 217 S. Paul St.
19. APR 21 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1948, at 12-40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 19 1948 to April 20 1948, and that I last saw him alive on April 20 1948.

Immediate cause of death ~~Pulmonary tuberculosis~~
Due to Bronchiectasis
Due to (or)
Other Conditions ~~Tuberculosis~~ Emphysema
(Including pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: Same as above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(e) Means of injury

23. Signature Wm. R. Dearmond, M.D. M. D.
Address Balto City Hosp. Date signed 4-20-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

662455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

662455 Registered No.

662455 CM. 118876

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 22 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Whatcoat ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dot Corrine Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	M

6 (b) Name of husband or wife William Jones
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Feb. 20 - 1910

8. AGE: Years	Months	Days	If less than one day: hr.	min.
38	1			

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Butler
13. Birthplace MD.

MOTHER
14. Maiden Name Fannie Lee
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 21/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Brooklyn
Location

18 (a) Funeral director Va Brooks
(b) Address 1763 N. Carey St

19 (a) APR 21 1948 (Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-18-- 1948, at 9.45PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4 - 12 - 1948, to 4 - 18 - 1948, and that I last saw DF alive on 4 - 18 - 1948.

Immediate cause of death Relief For Advanced Pulm. TBc. — Duration 2 yrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work)
(e) Means of injury

23. Signature John Edward Morrison M.D.
Address Balto. City Hosp. Date signed 4/19/48

YS 550

C62456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C62456

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4648 Park Heights Ave
(c) Hospital or institution: 27-16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4648 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Freeman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Morris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 62 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: unknown
13. Birthplace: Russia

MOTHER
14. Maiden Name: unknown
15. Birthplace: Russia

16 (a) Informant: Morris Freeman
(b) Address: 4648 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-21-48 (month) (day) (year)
(c) Cemetery or crematory
Location: Hebrew Herring Run

18 (a) Funeral director: Jack Levoth Inc
(b) Address: 200 Eutaw Place

19 APR 21 1948 (Date received by registrar) Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 20 - 1948, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948, to Apr 20 1948, and that I last saw her alive on Apr 20 1948.

Immediate cause of death
Coronary Thrombosis — Duration: instant

Due to Acute Indigestion + Gall Bladder Attack — 1 day

Due to

Other Conditions Arteriosclerosis Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature: Lester N. Kalman M.D.
Address 3700 Park Heights Ave Date signed Apr 20 1948

G62457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

X G62457 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) same

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Annapolis (If outside city or town limits write RURAL and give town)
(d) Street No. 77 Prince George (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Susan Agnes Holland.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frederick Holland
6 (c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Dec 28, 1887

8. AGE: Years	Months	Days	If less than one day: hr	min
60	3	23	4	

9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: House wife
11. Industry or business

FATHER
12. Name: George Parkinson
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Ann Lee ?
15. Birthplace: Maryland

16 (a) Informant: Mrs. H. Solomon-Lazarus
(b) Address: Annapolis Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/24/48 (month) (day) (year)
(c) Cemetery or crematory: St Marys Gem
Location: Annapolis Md

18 (a) Funeral director: E Wilds Lamereau
(b) Address: 1003 W. Baltimore St.

19 (a) APR 9 1948 (Date received by Registrar) (b) Registrar: Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1948, at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1948 to April 21 1948, and that I last saw her alive on April 21 1948.

Immediate cause of death Uremia — Duration: 1 mo

Due to Chronic Pyelonephritis — Duration: years

Due to

Other Conditions Hypertension C.V. Disease.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work?)
(e) Means of injury

23. Signature: W. F. Schnitzler M. D.
Address: Annapolis
Date signed: 8-2-48

133a

C62458

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

82 B

Registered No. C62458

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3908 N. Charles St.
(c) Hospital or institution: none 12-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 N. Charles St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Emma T. Eager

3 (b) If veteran, name war

3 (c) Social Security Account No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife John Howard Eager
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr Oct. 25, 1875

8. AGE: Years	Months	Days	If less than one day
72	5	26	hr min

9. Birthplace Nashville, Tenn. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Joseph Hamilton Thompson
13. Birthplace Tenn.

MOTHER
14. Maiden Name Ella Vaughn
15. Birthplace Tenn.

16 (a) Informant John H. Eager
(b) Address 3908 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Nashville Tenn.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) APR 21 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9, 1940 to April 20, 1948 and that I last saw h alive on April 19 1948.

Immediate cause of death: Cerebral thrombosis — Duration 2 - 3 days

Due to: Arteriosclerosis

Due to:

Other Conditions: Malnutrition

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature John Tilden Howard M. D.
Address 12 E. Eager St. Date signed Apr. 20, 48

BC-48-08050

G62459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 152

G62459 Registered No.

TYPE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Sinai Hosp

(c) Hospital or institution: 6-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 410 N. Madeira St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Garnet Hopkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Mar. 28- 48

8. AGE: Years | Months | Days 22 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name Elizabeth Hopkins

15. Birthplace Balto. Md.

16 (a) Informant Elizabeth Hopkins

(b) Address 416 N. Madeira St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 21-48 (month) (day) (year)

(c) Cemetery or crematory Balto. Cem. Co.

Location North Ave. + Loy St.

18 (a) Funeral director John A. Miller

(b) Address 2334 Jefferson St.

APR 21 1948 (Date rec'd by registrar)

(b) Huntington Woolworth, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19, 1948 at 9:47 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 7, 1948 to April 19, 1948, and that I last saw her alive on April 19, 1948.

Immediate cause of death Staphylococcus septicemia. c multiple abscesses, brain, pulmonary,

Due to brain.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Stanley R. Steinberg

Address Sinai Hospital Date signed 4/19/48 M.D.

VS 150

X

C62460

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. C62460

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Cold Spring
(c) Hospital or institution: Cold Spring Nursing Home 27-15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 W. COLDSPRING LANE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Orem Kaldenback

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1885

8. AGE: Years 62 | Months 5 | Days 26 | If less than one day: hr. 27 min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business

FATHER — 12. Name JOHN M. KALDENBACK
13. Birthplace MD

MOTHER — 14. Maiden Name ANNA C ALST
15. Birthplace MD.

16 (a) Informant MRS MARGARET E HART
(b) Address 806 N. AUGUSTA AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APRIL 22 '48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location 3801 FREDERICK RD

18 (a) Funeral director Harry Sam Wythe
(b) Address 4101 Edmondson Ave

19 (a) APR 21 1948 (Date rec'd by registrar) (b) Lexington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1948 at 3 56 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1946 to April 19 1948; and that I last saw him alive on April 19 1948.

	Duration
Immediate cause of death: CEREBRAL HEMORRHAGE	6 yrs.
Due to: Hypertensive CARDIO-VASCULAR DISEASE	10 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R. Kleiman M.D.
Address 3803 Edmondson Ave Date signed 4/19/48

C62461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. C62461

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1502 W. Fayette St
(c) Hospital or institution: 19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimor
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1502 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Margaret R. Mabbott

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Married

6 (b) Name of husband or wife Frank L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1896

8. AGE: Years	Months	Days	If less than one day
51	11	14	hr. min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name — Allman
13. Birthplace N. C.

MOTHER
14. Maiden Name —
15. Birthplace N. C.

16 (a) Informant Mrs. Frank Mabbott
(b) Address 1502 W. Fayette St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/48 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto. Md.
18 (a) Funeral director Henry A Withey
(b) Address 4101 Edmondson Ave
19 (a) APR 21 1948 Huntington Williams Mill
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. **DATE OF DEATH** April 19 1948 at M
21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to April 19 1948 and that I last saw her alive on April 19 48.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Milton Iscovitz M. D.
Address 1424 W Fayette Date signed 4/20/48

VS 150

662462

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

Registered No. 662462

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1800 W. BALTIMORE ST
(c) Hospital or institution: 20-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1800 W. BALTIMORE ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN P WARD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6 (b) Name of husband or wife Late MARY E (WALTERS)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 28, 1854

8. AGE: Years	Months	Days	If less than one day
93	10	21 22	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation COAL DEALER
11. Industry or business OWN BUSINESS

FATHER
12. Name — WARD
13. Birthplace MD

MOTHER
14. Maiden Name SARAH —
15. Birthplace MD

16 (a) Informant MRS JOSEPH BAER (DAUGHTER)
(b) Address 1800 W BALTIMORE ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APRIL 22 '48 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE
Location NINTH AVE & GAY ST

18 (a) Funeral director Harry A Dyche
(b) Address 4101 Eastern Ave

19 (a) APR 21 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS - 160

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 19 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/8 1947 to 4/19 1948.
and that I last saw him alive on 4/19 1948.

Immediate cause of death Senility — Duration ?
Due to Arteriosclerosis. — ?
Due to Prostatic Hypertrophy 3°. — 4yrs.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry E. Hoyer Asst
Address 1905 W. Balto. Date signed 4/20/48.

662463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G62163 5698
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1704 W Lanvale St.
(c) Hospital or institution: 16-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 14yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 W. Lanvale St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mary Fendelburgh
3 (b) If veteran, name war
(c) Social Security Account No.

4. Sex: female | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Hamp Fendelburgh
6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) Dec 13, 1883
8. AGE: Years: 64 | Months: 4 | Days: 6 | If less than one day: hr. ___ min. ___
9. Birthplace: Wadesboro N. C. (Town, county, and state)
10. Usual Occupation: Domestic
11. Industry or business: Own home

FATHER
12. Name: Handy Griffin
13. Birthplace: N. C.

MOTHER
14. Maiden Name: Caroline Thomas
15. Birthplace: N. C.

16 (a) Informant: Mrs Bessie Woods
(b) Address: 1704 Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/48 (month) (day) (year)
(c) Cemetery or crematory: Arbutus
Location: Md

18 (a) Funeral director: Geo. E. Kelly
(b) Address: 1303 Pennsylvania Ave

19 (Date rec'd by registrar) APR 21 1948 (Huntington Williams) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-19- 1948 at 11:15 PM
21. I certify that death occurred on the date above stated, that I attended deceased from 4-5 1948 to 4-19 1948, and that I last saw her alive on 4-19- 1948

Immediate cause of death: Cerebral hemorrhage — Duration: 5 days
Due to
Due to Hypertension + Arteriosclerosis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature: Frank A. Saunders M. D.
Address: 1029 N. Stricker St. Date signed 4-20-48

VS 150

X

G62464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G62464

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 512 n. Calhoun St
(c) Hospital or institution: 19-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 n. Calhoun St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary J. Molock

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	married

6 (b) Name of husband or wife Clarence Molock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) aug 19, 1888

8. AGE: Years	Months	Days	If less than one day
59	8	-	hr. min.

9. Birthplace md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Colman
13. Birthplace md

MOTHER
14. Maiden Name Elizabeth Baltimore
15. Birthplace md

16 (a) Informant Clarence Molock
(b) Address 512 n. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-22-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location (Town) md

18 (a) Funeral director George E. Kelson
(b) Address 1913 Pressman St.

19 (a) APR 21 1948 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH april 19 1948 at 1 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 25 1948 to Apr 19 1948, and that I last saw h alive on Apr 19 1948.

Immediate cause of death

Chronic Valvular Heart Disease — Duration 6 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Watts
Address 515 Arlington Date signed 4/20/48

VS 150

C62465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

Registered No. C62465

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 104 N. Milton Ave
(c) Hospital or institution: 6-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 104 N. Milton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Phelan

3 (b) If veteran, name war O | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Patrick J. Phelan 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 13, 1865

8. AGE: Years	Months	Days	If less than one day
82	6	6	hr. min.

9. Birthplace Balt. Maryland (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Michael Flynn
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Kane
15. Birthplace Ireland

16 (a) Informant Mae A. Phelan
(b) Address 104 N. Milton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-22-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Fredrick Rd

18 (a) Funeral director John A. Moran
(b) Address 700 E. Balt. St.

19 (a) APR 21 1948 (Date rec'd by registrar) (b) Huntingtown Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 19 1948, at 1 30 M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Apr 19 1948.
and that I last saw h alive on Apr 18 1948.

Immediate cause of death Terminal Pneumonia — Duration 1 hr.
Due to Hypertension Heart Disease — 4 yrs.
Due to Chronic anemia
Other Conditions Arter. Sclerosis.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E N Mercer M. D.
Address 1520 E. 33rd St. Date signed 4/19/48

VS 150

G62466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G62466

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4732 Old York Road
(c) Hospital or institution: — 27-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4732 Old York Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mary Catherine Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Edward A. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1871

8. AGE: Years	Months	Days	If less than one day
76	10	8	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name John Campaigne Smith
13. Birthplace Ireland

MOTHER
14. Maiden Name Henrietta Warfield
15. Birthplace Howard Co., Md.

16 (a) Informant Mrs Frances Flanagan
(b) Address 4732 Old York Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 24 1948 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Govans

18 (a) Funeral director John C Moran
(b) Address 3600 Baltimore St

19 (a) APR 21 1948 (Date rec'd by registrar) (b) By [illegible] for Hilliard M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1948 at 12:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1946 to April 20 1948, and that I last saw h.w. alive on April 18 1948

Immediate cause of death	Duration
Cachexia	6 mos
Due to Carcinoma rectum with abdominal metastases	18 mos.
Due to	
Other Conditions Generalized arteriosclerosis	2 yrs

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature Frederick J. Vollmer M. D.
Address 6100 York Road Date signed 4-20-48

C62467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C62467

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4504 Garrison Boulevard
(c) Hospital or institution: 15-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4504 Garrison Boulevard (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E. MESSERSMITH

3 (b) If veteran, name war: --

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widow

6 (b) Name of husband or wife Charles H. Messersmith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1876

8. AGE: Years	Months	Days	If less than one day: hr.	min.
71	5	25		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Andrew Reiter
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Marx
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. W. Irving Jones
(b) Address 4504 Garrison Boulevard

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas J. Evans Son Inc
(b) Address 118 N. Mt. Royal Ave

19 (a) 4-20-48 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 19 48 at 1 49 M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/11 19 44 to 4/19 19 48.
and that I last saw her alive on 4/18 19 48.

Immediate cause of death: Cerebral hemorrhage — Duration: 2 wks.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Patient A. Reiter
Address 3408 Windsor Ave Date signed 4/20/48 M. D.

VS 150

X

662468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

Registered No. 662468

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12-V
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. Cambridge Arms Apt 1 (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Haas
3 (b) If veteran, name war
3 (c) Social Security Account No 220-09-6166

MEDICAL CERTIFICATION

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Marie Maloney Haas
6 (c) If alive, give age years

20. DATE OF DEATH April 19 1948, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 18 1947 to April 19 1948; and that I last saw him alive on April 19 1948

7. Birth date of deceased mo., day, yr. 12-24-65
8. AGE: Years 82 Months 3 Days 25 If less than one day hr. min.
9. Birthplace Maryland (City or county, State)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name John Haas
13. Birthplace Germany

MOTHER
14. Maiden Name Johanna Augustin
15. Birthplace Germany

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial, cremation, or removal EVTPA (b) Date thereof (month, day, year) 4-23-48
(c) Cemetery or crematory HOLY REDEEMER
Location

18 (a) Funeral director Chas. J. Evans
(b) Address 18 N. Mt. Street

19 (a) Date received by local registrar APR 21 1948 Signature for Williams, M.D.

Immediate cause of death: Carcinomatosis
Due to Ca prostate
Due to
Other Conditions Anemia
(Describe pregnancy within three months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury
23. Signature Peter P. Scardini M. D.
Address 1 A A Date signed 4-19-48

662169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178c

662469
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos. or days): 2 yrs
(e) Length of stay in Baltimore (yrs., mos. or days):

12-V

2. USUAL RESIDENCE OF DECEASED
(a) State: Md
(b) City or town: Baltimore
(c) Street No.: 3 E. 33rd Street
(d) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME: George W. CROMER

5 (b) If veteran, name war: No

(c) Social Security Account No. 217-01-1940

4. Sex: M
5. Color or race: C
6. Single, married, widowed or divorced: Widowed

6 (b) Name of husband or wife:
6 (c) If alive, give age:

7. Birth date of deceased: March 15, 1894

8. AGE: Years: 64 Mos.: 1 Days:

9. Birthplace: South Carolina

10. Usual Occupation: Janitor or elevator
11. Industry or business:

FATHER
12. Name: Samuel Cromer
13. Birthplace: South Carolina

MOTHER
14. Maiden Name: Martha Williams
15. Birthplace: South Carolina

16. (a) Informant: Elizabeth M. Jackson (daughter)
(b) Address: 624 Peach Orchard Lane

17. (a) Burial
(b) Date thereof: 4/22/48
(c) Cemetery or crematory: Western Star Cem.
Location: Balto. County, Md.

18. (a) Funeral director: Charles O. Cooper
(b) Address: 810-12 Edgarrollton Ave.

APR 21 1948

Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19 1948 at 9:30 P.M.

21. I hereby certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (supplemented by inquiry) find that said deceased came to his death on the day stated above, and death was not (question marked) from natural causes, (X) accident or suicide ( ) homicide ( ) undetermined ( ) and that the cause of death was:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to inhalation of smoke
— Burns (all) upper body

Other Conditions:

22. If employment caused (was) accidental ( ) causes of death (X) or the following:
(a) Date of injury: 3-19-48
(b) Where did injury occur? 3 E. 33rd St.
Did injury occur at home, in public place, or industry? Home
(d) Means of injury: Burns

21. Signature: George W. Merrill M.D.
Medical Examiner
Date signed: 4/19/48

Ad 7 062470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

062470

Registered No. 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or town, years, months or days
(e) Length of stay in Baltimore, years, months or days

2. USUAL RESIDENCE OF DECEASED
a. State Md. City of Baltimore
b. City or town Catonsville
c. Street No. Belfast Rd
d. Citizen of foreign country? If yes or No
If yes, native country

3. a. FULL NAME James H Taylor
3 (b) If veteran, name war
3 (c) Social Security Number None
4. Sex male
5. Color or race Colored
6. a. Single, married, widowed, or divorced single
6. b. Name of husband or wife
6. c. If widow, give age
7. Birth date of deceased Dec 8 31
8. AGE Years 1 Months 6 Days If under one day
9. Birthplace Md
10. Usual Occupation Chauffeur
11. Industry or business
FATHER 12. Name Albert H Taylor
13. Birthplace Md
MOTHER 14. Maiden Name Nellie Jones
15. Birthplace Md
16. a. Informant
b. Address JOHNS HOPKINS HOSPITAL
17. a. Burial, cremation, or removal Burial Date thereof Apr 24, 1932
b. Cemetery or crematory Druid
Location Catonsville
18. a. Funeral director Lincoln M. Taylor
b. Address Catonsville, Md.
Apr 23 1932 Date filed
Lexington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 20 1932
21. I certify that I last saw deceased on Apr 20 1932 and that death occurred on Apr 20 1932 at 8 P.M. and that I last saw deceased alive on Apr 20 1932
Immediate cause of death Shock
Due to Typhoid fever
Due to
Due to
Other conditions

Operation
Date of operation
Major findings of operation

PHYSICIAN
Underline the cause to which death should be charged statistically

If death was due to external causes, fill in the following:
Accident, suicide or homicide
Date of occurrence at M.
Where did injury occur? (City, town or county) (State)
Did injury occur while at work? (Specify yes or no)
How did injury occur?
Means of injury
Signature M. Swank
Address Johns Hopkins Hospital Date signed Apr 24 1932

66274 ✓ 66272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Maryland (Country)
(b) City or town Baltimore (If outside city or town limits, write R.F.D. and give name)
(c) Street No. 913 Eutaw Place (If rural, give location)
(d) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ann Carey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex f | 5. Color or race w | 6 (a) Single, married, widowed, or divorced single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years 78 | Months | Days | If less than one day: hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Never married.

11. Industry or business

FATHER
12. Name Jeremiah Carey
13. Birthplace Ireland

MOTHER
14. Maiden Name Ann E Linn
15. Birthplace Ireland

16 (a) Informant Mr. J. Kelly.
(b) Address 1508 Latrobe Park Terr

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/48 (month, day, year)
(c) Cemetery or crematory Fairmount
Location Frederick Rd. Catonsville, Md.

18 (a) Funeral director Thos. J. Kane
(b) Address 1111 Eutaw Place

19 (a) (Registrar) (b) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/19/48 19 .305A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐, and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within three months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (What street?)
(d) Means of injury

23. Signature John R Davis, Medical Examiner
Date signed 4/19/48

VS 151

G62472 BALTIMORE CITY HEALTH DEPARTMENT G62472
Registered No.

CERTIFICATE OF DEATH

170C

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2305 Mc Culloh ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State New York County
(c) City or town New York.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 131 W. 112th ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** James Elijah Turner Green.

3 (b) **If veteran, name war**

3 (c) **Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Colored	Married.

6 (b) **Name of husband or wife** Naomi Quinn Green.
6 (c) **If alive, give age** 31 years

7. **Birth date of deceased (mo., day, yr.)** May 19, 1906

8. AGE: Years	Months	Days	If less than one day hr.	min.
41	11	2		

9. **Birthplace** Chester Maryland.
(Town, county, and state)
10. **Usual Occupation** Chauffeur.
11. **Industry or business**

FATHER
12. Name George H. Greene
13. Birthplace Kent Island md.

MOTHER
14. Maiden Name Mary Catherine Turner.
15. Birthplace Kent Island.

16 (a) **Informant** Mrs Anita Clark.
(b) **Address** 2413 Woodbrook Ave.

17 (a) Burial (b) Date thereof April 25-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cemetary
Location Chester md

18 (a) Funeral director Lewis A Henry
(b) Address Centerville md

APR 24 1948
(Date rec'd by registrar) (b) Registrar

Huntington Nottingham, Md

VS 150

MEDICAL CERTIFICATION

20. **DATE OF DEATH** April 21 1948 at 3.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 12 1948 to April 20 1948 and that I last saw him alive on Apr 20 1948.

Immediate cause of death
Panting Hemorrhage.
Due to Automobile Accident
Due to
Other Conditions
Hyper Tension.
(Include pregnancy within 3 months of death)

Duration
a
b
c
d

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence November 21, 1947 ? M.
(c) Where did injury occur? New York City, NY
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public While at work? Yes
(Specify type of place)
(e) Means of injury Auto and Truck Collision

23. **Signature** Howard J. Masters M.D.
Address 2024 Madison Ave. Date signed 4/24/48

Howard J. Masters, M.D.

G62473

BALTIMORE CITY HEALTH DEPARTMENT ✓ G62473 Registered No.

CERTIFICATE OF DEATH 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Westwood Ave
(c) Hospital or institution: 15-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Westwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel R Palango Or Lang

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lillian
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1899

8. AGE: Years	Months	Days	If less than one day
48	4	18	hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation
11. Industry or business Cab Driver

FATHER
12. Name Domonic Palango
13. Birthplace Italy

MOTHER
14. Maiden Name Mary
15. Birthplace Italy

16 (a) Informant Mrs Lillian Palango Lang
(b) Address 2211 Westwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/48 (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew
Location Belair Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) [illegible] registrar (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1948, at 6 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 20 1948 to April 21 1948, and that I last saw h[illegible] alive on 20 April 1948

Immediate cause of death Coronary Thrombosis.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. E. Steele M. D.
Address 1814 W. North Ave Date signed 4/24/48

X

G62474

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G62474
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 717 Harvey St.
(c) Hospital or institution: 24 hr

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 717 Harvey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Norgran

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-07-5573

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 2 - 1870

8. AGE: Years	Months	Days	If less than one day
77	6	17	hr. min.

9. Birthplace Finland (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Joseph Norgran
13. Birthplace Finland

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Richard A. Knight
(b) Address 1434 E. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 23-1948 (month) (day) (year)
(c) Cemetery or crematory Lahmanty Cem
Location

18 (a) Funeral director Joseph Tarase Inc
(b) Address 2013 Bleenmount Ave.

19 APR 21 1948 (Date received by registrar) (b) Huntington Woods, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1948 at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1948 to April 19 1948, and that I last saw [illegible] alive on April 19 1948.

Immediate cause of death

Duration
Myocardial Insufficiency
Due to
Due to
Other Conditions Arteriosclerosis, Hypertension

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry A. Schwenk, M.D.
Address 1337 S. Charles St Date signed 4/24/48

G62475 ✓ G62475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland 28-3

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2707 Lawina Rd. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Benjamin Burgunder (Benj. B. Burgunder)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced:

6 (b) Name of husband or wife: Selma

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 11-7-91

8. **AGE:** Years: 56 Months: 5 Days: 13 If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Merchant

11. Industry or business:

FATHER

12. Name: Henry Burgunder

13. Birthplace: Md

MOTHER

14. Maiden Name: Rose Bernei

15. Birthplace: Md

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/48 (month) (day) (year)

(c) Cemetery or crematory: Balto. Hebrew

Location: Balto. Md.

18 (a) Funeral director: David Sonnheim Hon

(b) Address: 902 Eutaw Place

19 (a) 4-21-48 (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1948, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/29 1948 to 4/20 1948, and that I last saw him alive on 4/20 1948

Immediate cause of death: Carcinoma tonsil

Due to: Mastoiditis from tumor of colon

Due to:

Other Conditions: Tumor right femur

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature: Howard T. Day M. D.

Address: Johns Hopkins Hosp. Date signed 4-20-48

C62476

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

C62476 Registered No. 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 727
(c) Hospital or institution Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city limits, write RURAL and give town)
(d) Street No. 735 W Mulberry St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country - - - -

3 (a) FULL NAME William F. Weber

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Catherine L. Weber

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 4-17-1874

8. AGE: Years 74 | Months 0 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Bottler

11. Industry or business American brewery

FATHER
12. Name Henry Weber
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary ?
15. Birthplace Baltimore

16 (a) Informant Catherine Aburns
(b) Address 2729 Fait Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/2[illegible] (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Edmondson Avenue Baltimore

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 103 South Wolfe Street 31

19 (a) Date rec'd by registrar APR 21 1948 (b) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1948 at 3:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Cerebral hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? ... (While at work?)
(d) Means of injury

23. Signature William F. Weber M.D. Medical Examiner.
Date signed 4/20/48

G624'77 — Lang G624'77

BALTIMORE CITY HEALTH DEPARTMENT — Registered No. 94a

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St.
(c) Hospital or institution: Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. Home for aged & Poor (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Lang

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1877

8. AGE: Years	Months	Days	If less than one day
71	2	9	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name John Lang
13. Birthplace

MOTHER — 14. Maiden Name Gertrude Vogel
15. Birthplace

16 (a) Informant Sister of the Poor
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, entombment) (b) Date thereof April 22 48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Belair Road

18 (a) Funeral director Schmuck Funeral Home
(b) Address 2601 E Madison St

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

APR 21 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1948 at 5:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apl 1 1948 to Apl 20 1948 and that I last saw him alive on April 19 1948.

Immediate cause of death

Edema Lungs — Duration: 1 day

Due to Coronary Thrombosis — Duration: 5 days

Due to — Duration:

Other Conditions Arteriosclerosis — Duration: 5 yrs.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E North Ave Date signed 4/20/48

Hunther G62478

G62478

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3618 Echodale Ave
(c) Hospital or institution: 27-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3618 Echodale Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Henry Hunther

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Mary Louise
6 (c) If single, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7-1895

8. AGE: Years	Months	Days	If less than one day: hr.	min.
53	2	13		

9. Birthplace Balto. Md. (Town, county and state)
10. Usual Occupation Md drydock
11. Industry or business Caulker

FATHER
12. Name John P. Hunther
13. Birthplace Md.

MOTHER
14. Maiden Name Julia Otto
15. Birthplace Md

16. (a) Informant Mrs. Mary L. Hunther
(b) Address 3618 Echodale Ave

17. (a) Buried (Burial, cremation, or removal) (b) Date thereof 4-23-48 (Month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18. (a) Funeral director Lerner & Rinck
(b) Address 5305 Harford Rd (Signature) for Williams, M.D. Registrar

19. (a) [illegible] (Proprietor)

APR 21 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 April 1948 at 8:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions (Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. M. Kammer Jr. M.D. (Medical Examiner)
Date signed 21 April 48

G62479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94

✓ G62479

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the cause of death clearly and legibly.

1. PLACE OF DEATH.

(a) Baltimore City, Maryland

(b) Street address Broadway - Fairmount Ave

(c) Hospital or institution (9-1)

Church Home & Hospital

(d) Length of stay in hospital or usual place of abode 8 days

(e) Length of stay in Baltimore if not there at death Life

2. FULL NAME Mr Lee Denson

3. (a) If veteran, name war

(b) Social Security Number

4. Sex M

5. Color or race W

6. If married, widowed, or divorced Widowed

7. Name of husband or wife Loretta Adams

8. Date of death (month, day, year) Apr 21, 1944

AGE Years 53 Months 7 Days 27

9. Birthplace Maryland

10. Usual Occupation Engineer

11. Industry or business Contractor

FATHER

12. Name Geo Denson

13. Birthplace Maryland

MOTHER

14. Maiden Name Mary Butler

15. Birthplace Maryland

16. (a) Informant Hospital Records

(b) Address

17. (a) Burial (Cremation or entombment) (Date) 4-24-44

(b) Cemetery or crematory Lorraine Park

Location Balto

18. (a) Funeral director Kirk

(b) Address 5305 Belair Rd Baltimore Md

19. (a) Date received

(b) Registrar

21

1. USUAL RESIDENCE OF DECEASED.

(a) State Maryland (County) Baltimore Co

(b) City or town Baltimore

(c) Street and number 1742 Homestead St

(d) Citizen of foreign country? No (Yes or No)

If yes, native country

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1944 6:30 A.M.

21. I hereby certify that I attended deceased from April 20 1944 to April 20 1944

that I last saw deceased alive on April 20 1944

Duration

The cause of death was as follows:

Thrombosis of Myocardium 1 hr

Coronary occlusion

Arteriosclerosis

PHYSICIAN

(a) Date of signature

(b) Usual residence of signer

(c) Name and address of institution where death occurred or name of attending physician

as above.

(d) Date of signature

(e) Where did signer see deceased?

(f) Did signer view body after death?

(g) Time of viewing

(h) Cause of death

(i) Signature Kirk Moore MD

(j) Address Church Home - Hosp Date signed 4-20-44

(52180) ✓ (52180)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The...

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address 2913 GARDEN Ave
(c) Hospital or institution
(d) Length of stay in hospital or state: yrs. mos. or days
(e) Length of stay in Baltimore: yrs. mos. or days

27-24

2. USUAL RESIDENCE OF DECEASED
a. State MD
b. City or town Baltimore
c. Street No. 2913 Duncan Ave
d. Citizen of foreign country? Yes or No?
If yes, name country

3 (a) FULL NAME William L Beardsley

3 (b) If veteran, name war: No
3 (c) Social Security Number: No

4. Sex: M
5. Color or race: W
6. Single, married, widowed, or divorced: M
6. (b) Name of husband or wife: Mary E Beardsley
If widow, give age:
7. Birth date of deceased: day yr Apr 26, 1901
8. AGE: Years 40 | Months 11 | Days 25
If less than one day, hr. or min.
9. Birthplace: BALTO., MD
(Town, county and state)
10. Usual Occupation
11. Industry or business: BEANS MOTORS

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 20 19 28 at 10 A.M.
21. I certify that I took charge of the remains described above, held an autopsy, (have seen and know the circumstances attending) (made inspection of) the body of deceased, and that I last saw deceased alive on June 20 1928, and that death occurred on the date stated above, and that to my opinion deceased came to his death from natural causes, accidental, suicidal, homicidal, undetermined, and that the causes of death were
IMMEDIATE CAUSE OF DEATH: Cardiac Stenosis
Due to
Other Conditions

FATHER
12. Name: Wm L BEARDSLEY JR
13. Birthplace: BALTO, MD

MOTHER
14. Maiden Name: LORETTA YEAGER
15. Birthplace: BALTO., MD

16. (a) Informant: Mrs LORETTA BEARDSLEY
(b) Address: OLD Court Rd - Pikesville, MD

17. (a) BURIAL (Burial, cremation, or removal) (b) Date: 6/21/28
(c) Cemetery: LOUDON PK
Location: BALTO MD.

18. (a) Funeral director: Wm J. TILKNER & SON
(b) Address: BALTO. MD

19. 21 June Interred Arlington Cemetery MD

22. If an external cause was probably the cause (directly or indirectly) of death, fill in the following:
a. Date of injury
b. Where did injury occur?
c. Did injury occur in home, on farm, industrial plant, in public place?
d. Nature of injury
e. Signature
Date signed: June 20 1928

M.D.

VS 101

G62181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G62181 Registered No.

4½ E

PLEASE WRITE PLAINLY—WITH UNFADING INK. Every item of information should be carefully supplied. Physicians please write the cause of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
(a) Baltimore City Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or institution: yrs. mos. or days
(e) Length of stay in Baltimore: yrs. mos. or days

2. USUAL RESIDENCE OF DECEASED
a. State: Ill
b. County
c. City or town: Highland Park
If outside city or town limits, write RURAL and give name of township
d. Street No.: 731 Crofton Rd.
If rural, give location
e. Length of residence in city or town: Yrs. or Mos.
If less than 1 year, previous residence

3. a. FULL NAME: Mrs. Esther Immerwahr
b. If veteran, name war: None
c. Social Security Account No.

4. Sex: Male
5. Color or race: White
6. a. Single, married, widowed or divorced: Married
b. Name of husband or wife: Esther
c. If widow, give age: years

7. Birth date of deceased: month day year: April 24, 1880
8. AGE: Years 67, Months 11, Days 26. If less than one day, hours or minutes

9. Birthplace: New York City (Town, county and state)
10. Usual Occupation: Paper Merchant
11. Industry or business

PARENTS
12. Name: George Immerwahr
13. Birthplace: Germany

MAIDEN NAME OF WIFE
14. Maiden Name: Nathalie Schlesinger
15. Birthplace: Germany

16. a. Informant: Mrs. Esther Immerwahr
b. Address: 731 Crofton Rd.

17. a. Burial, cremation or removal: Removal
b. Date thereof: month 4, day 21, year 48
c. Cemetery or crematory
Location: Chicago, Ill

18. a. Funeral director: William J. Tickner & Sons
b. Address: North & [illegible]

19. Year 1948
(b) Name of registrar
(c) Registered Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 1948 at 12:15 P.M.

21. I certify that death occurred on the date above stated, that I attended the deceased from 3/3 1948 to 4/20 1948, and that I last saw him alive on 4/20 1948

Immediate cause of death
Uremia
Due to: Carcinomatosis
Due to: Carcinoma of colon

Other significant conditions contributing to death but not related to terminal disease

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

Date of operation
Major findings of operation

Was autopsy performed?

22. If death was due to external causes, fill in the following:
a. Accident, suicide or homicide
b. Date of occurrence: at M
c. Where did injury occur? (City or town) (County) (State)
d. Did injury occur in or about home, on farm, industrial place or public place? (Specify)
e. Means of injury
f. Signature: Irving Ingalls
Address: Sinai Hospital Date signed: 4/20/48

X

G62482

BALTIMORE CITY HEALTH DEPARTMENT ✓ G62482 **Registered No.**

CERTIFICATE OF DEATH 124B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 15-8
(b) Street address
(c) Hospital or institution: Church Home & Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43 days
(e) Length of stay in Baltimore (yrs., mos., or days) 29 years

2. USUAL RESIDENCE OF DECEASED:
a State Md. (b) County
c City or town Baltimore 16
(If outside city or town limits, write RURAL and give town)
d Street No. 2302 Ledgen Avenue
(If rural give location)
(f) Citizen of foreign country? no If yes, name country

3 (a) FULL NAME BAKER CHARLES A CLARKE
3 (b) If veteran, name war W.W. I
3 (c) Social Security Account No.
4. Sex Male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced divorced
6 (b) Name of husband or wife.
6 (c) If alive, give age years
7. Birth date of deceased mo. day yr. 10-31-98
8. AGE: Years 49 | Months 5 | Days 18 | If less than one day hr. min.
9. Birthplace (town, county, and state) Kearneysville, W. Va.
10. Usual Occupation Lineman
11. Industry or business Telephone Co. C & P.
12. Name of FATHER Thomas J. Clarke
13. Birthplace of FATHER Baltimore Co. Md.
14. Maiden Name of MOTHER Hannah M. Burnett
15. Birthplace of MOTHER Kearneysville, W. Va.
16 (a) Informant Mrs. R. H. Bennett
(b) Address 15- Blaine Hill Rd. Woodbourne
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/48 (month) (day) (year)
(c) Cemetery or crematory Mount Ridge
Location Pikesville, Md.
18 (a) Funeral director Wm. J. Trebus & Sons
(b) Address Balto., Md.
19 (a) (By whom certified) (b) Filed by registrar Williamsport, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 APRIL 1948 at 4:34 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 3-8 1948 to 4-19- 1948 and that I last saw h[illegible] alive on 4-19- 1948

Immediate cause of death
CHRONIC DUODENAL ULCER WITH OBSTRUCTIVE SYMPTOMS — Duration 20 years
Due to Pyloric gastro enterostomy — Duration
Due to Gastroenterostomy — Duration
(ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).)

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 4-8-48 & 4-15-48
Major findings of operation: CIRRHOSIS OF LIVER - CHRONIC PEPTIC ULCER
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place) While at work) (Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address Church Home Date signed 4-21-48

VS 150

X

G62183 ✓ G62183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. _____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Linden Ave & Madison St

(c) Hospital or institution: Maryland Gen Hosp 15-1

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1623 West North Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME [redacted] CECIL CALVERT MARCHANT

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Sayde Katz

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Aug. 11th 1877

8. AGE: Years	Months	Days	If less than one day
70	8	9	hr. ____ min.

9. Birthplace Matthews Co. Va. (Town, county, and state)

10. Usual Occupation Retired Dentist

11. Industry or business

FATHER — 12. Name ? Marchant

FATHER — 13. Birthplace Unknown

MOTHER — 14. Maiden Name Unknown

MOTHER — 15. Birthplace Unknown

16 (a) Informant Mrs. Florence Fitzgerald

(b) Address 5 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/48 (month) (day) (year)

(c) Cemetery or crematory Lorraine Cem.

Location Woodlawn Md.

18 (a) Funeral director William J. Tickner & Sons

(b) Address North & Pennsylvania Aves.

19 Filed [illegible] (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-20-48 19 , at 3 0/24 HM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-19 1948 to 4-20 1948, and that I last saw him alive on 4-20 1948.

Immediate cause of death Cardio respiratory failure

Due to Cerebral accident

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature D. Davis Hunt M. D.

Address Md Gen Hosp Date signed 4/20/48

To effect burial, by Board of Health, M.C.

C62484 SC-48-07455 ✓ C62484

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St + Linden Ave
(c) Hospital or institution: Maryland General Hospital 18 C 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 836 W. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Williams A

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8 April 1948

8. AGE: Years	Months	Days	If less than one day
			11 hr. 20 min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business

FATHER — 12. Name Frank Williams
13. Birthplace Maryland

MOTHER — 14. Maiden Name Willetta Zapp
15. Birthplace Maryland

16 (a) Informant Father
(b) Address 836 W Pratt St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 APR 21 1948 (Date rec'd by Registrar) (b) Hunting for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 April 1948, at 5:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 8 Apr 1948 to 8 Apr 1948, and that I last saw h alive on 8 Apr 1948.

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Prematurity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Allan Aust
Address Md. Gen. Hosp. Date signed 8 Apr 48

APR 16, 1948
Commissioner of Health

VS 150

G62185 BC-48-07956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G62185

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution. Franklin Square 26-04
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4808 Oranelle Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Boy Robert (Ralph Edward Robert)

3 (b) If veteran, name war —
(c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/14/48

8. AGE: Years	Months	Days	If less than one day
			12 hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Race
11. Industry or business —

MOTHER / FATHER
12. Name Roland Lavergne Robert
13. Birthplace Shamokin, Pa
14. Maiden Name Ethel Mavis Sigler
15. Birthplace Lancaster, S. C.

16 (a) Informant Mother
(b) Address 4808 Oranelle Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location Johns Hopkins Medical School APR 16, 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) APR 21 1948 (Received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-14 1948, at 12:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-14 1948, to 4-14 1948, and that I last saw him alive on 4-14 1948.

Immediate cause of death Atelectasis

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard J. Cooper M. D.
Address Franklin Sq Hosp Date signed 4-15-48

VS 150

X

62486 BC-48-07730 ✓ 62486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: Woman's Hospital 17-03
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2616 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country —

3 (a) FULL NAME Baby Boy Keith

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 4/11/48

8. AGE: Years — | Months — | Days 1 | If less than one day — hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Irvin William Keith

13. Birthplace Ellicott City, Md

MOTHER 14. Maiden Name Mary Ruth Bell

15. Birthplace Baltimore County, Md.

16 (a) Informant Mother

(b) Address 2616 Greenmount Ave, Balto-18

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Johns Hopkins Medical School APR 15, 1948

18 (a) Funeral director Commissioner of Health

(b) Address —

APR 21 1948 (Date received) (Registrar) Commissioner of Health

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/13/48 19 . at 12 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/9/48 19 . to 4/13/48 19 . and that I last saw him alive on 4/13/48 19 .

Immediate cause of death Intra-Cranial Hemorrhage — Duration

Due to Prematurity

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature W. L. Sumpter

Address Woman's Hospital Date signed 4/13/48

VS 150

G62487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 128

G62487 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age and date of birth are especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Newport News (If outside city or town limits, write RURAL and give town)
(d) Street No. 801-A 33rd St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Katherine Ross
3 (b) If veteran, name war
3 (c) Social Security Account No.
4 Sex: female
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) 12-30-47
8. AGE: Years | Months 3 | Days 21 | If less than one day hr. min
9. Birthplace NEWPORT NEWS, VA. (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Calvert Ross
13. Birthplace Penn
MOTHER 14. Maiden Name Emily Ross
15. Birthplace Va Penna
16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-22-48 (month) (day) (year)
(c) Cemetery or crematory Greenlawn Location Newport News, Va.
18 (a) Funeral director Peninsula Funeral Home
(b) Address Newport News, Va.
19 (a) Date received by registrar APR 21 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1948, at 9:00 A M
21. I certify that death occurred on the date above stated; that I attended deceased from April 19 1948, to April 20 1948, and that I last saw her alive on April 20 1948.
Immediate cause of death respiratory failure
Due to Cystic Fibrosis of Pancreas
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature J. Julian Chisolm Jr. M. D.
Address Johns Hopkins Hospital Date signed 4-23-48

Turlington for Williams, MD

VS 150

G62488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G62488 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton + Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Mos
(e) Length of stay in Baltimore (yrs., mos., or days) 42 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. St Marys Seminary Roland Pk (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rev. Andrew Levatois S. S.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: M. | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Clergyman

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1 - 1871

8. AGE: Years 76 | Months 6 | Days 19 | If less than one day hr. min.

9. Birthplace Saint Loup France (Town, county, and state)

10. Usual Occupation Clergyman

11. Industry or business

FATHER
12. Name Alexander Levatois
13. Birthplace France

MOTHER
14. Maiden Name Julia Lepeca
15. Birthplace France

16 (a) Informant St. Mary's Seminary Record
(b) Address Roland Park

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/48 (month) (day) (year)
(c) Cemetery or crematory St. Charles
Location Catonsville

18 (a) Funeral director H. W. Miears Son
(b) Address 805 N. Calvert Street

19 [illegible] 21 1948 Huntington Williams, M.D. Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/20 1948 at 7.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1947 to 4/20 1948.
and that I last saw h[illegible] alive on 4/20 1948.

Immediate cause of death Cardiac failure, Hypertension c. CVD and arteriosclerosis — Duration

Due to Prostate Disease

Due to Bone

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address [illegible] Date signed 4/20 1948 M. D.

G62489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G62489 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Lexington St
(c) Hospital or institution: Aged Women's + Aged Men's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yr
(e) Length of stay in Baltimore (yrs., mos., or days) 17

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W LEXINGTON ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME A. Kirk Anderson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 23 1857

8. AGE: Years 90 | Months 5 | Days 28 | If less than one day hr. min.

9. Birthplace Hanover Co. Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John R Anderson
13. Birthplace Richmond Va.

MOTHER 14. Maiden Name Martha Heslerin
15. Birthplace Richmond Va

16 (a) Informant L. K. Read Supt.
(b) Address 1400 N. Lexington St

17 Burial (Burial, cremation, or removal) (b) Date thereof 4/21/48 (month) (day) (year)

(c) Cemetery or crematory Lexington
Location Lexington Ky

18 (a) Funeral director McCormick
(b) Address 1219 Light St

19 (a) (Date received by registrar) (b) Registrar

APR 21 1948

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1948, at 5:00 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1948 to APR 1/20 1948, and that I last saw h[illegible] alive on APR 1/21 1948.

Immediate cause of death: Cardio-Respiratory failure — Duration

Due to Arteriosclerotic Myocarditis

Due to

Other Conditions Hypostatic Arteriosclerotic Cardio Vascular disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maryland Edward Day M. D.
Address 4-E-33rd St '18 Date signed April 21 1948

662490

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 94a

662490 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp 13 ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 725 Lennox St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Solomon KEEFER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M.

6 (b) Name of husband or wife Clara M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1-1885-

8. AGE: Years	Months	Days	If less than one day
62	4	20 14	hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Ship building

FATHER
12. Name Samuel Keefer
13. Birthplace ?

MOTHER
14. Maiden Name Smith
15. Birthplace ?

16 (a) Informant Mildred Kreiser
(b) Address Main Deposit Pa

17 (a) Removal (b) Date thereof 4/21/45
(Burial, cremation, or removal) (Month, day, year)
(c) Cemetery or crematory HANOVER DALE
Location Hanoverdale Pa.

18 (a) Funeral director Wm Cook Inc
(b) Address 217 S. Charles St

19 (a) (b)
(Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 45, at 1:05 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary artery disease

acute congestive cardiac failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.

Date signed 4/21/45

X

C62491 ✓ C62491

C62491

BALTIMORE CITY HEALTH DEPARTMENT Registered No.

CERTIFICATE OF DEATH 13B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hosp 27-19
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4317 Grandview Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Wh	Married

6 (b) Name of ~~husband or~~ wife Lola E. Thomas 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 12th 1874

8. AGE: Years	Months	Days	If less than one day
73	6	9	hr. min.

9. Birthplace Whitehall Md. (Town, county, and state)
10. Usual Occupation Retired Carpenter
11. Industry or business Penna. R.R.

FATHER
12. Name David N. Thomas
13. Birthplace New Oxford Pa.

MOTHER
14. Maiden Name Anna J. Nelson
15. Birthplace Md.

16 (a) Informant Lola E. Thomas
(b) Address 4317 Grandview Ave.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/23/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Vernon M. E. Church
Location Vernon, Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) APR 22 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1948, at 3 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 20 1948, to April 21 1948, and that I last saw him alive on April 21 1948.

Immediate cause of death Tuberculous pneumonia

Due to Pulmonary tuberculosis

Due to

Other Conditions Arteriosclerosis & arteriosclerotic heart disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M.D.
Address Univ. Hosp. Date signed 4/22/48

VS '50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G62492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12/a

Registered No. G62492

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 10 ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days): less than 1 day
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 817 Abbott Court (If rural give location)
(e) Citizen of foreign country? (Yes or No): no
If yes, name country:

3 (a) FULL NAME: George F. Sauers

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: yes - ?

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Edna Abel

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 4, 1892

8. AGE: Years: 55 | Months: 9 | Days: 16 | If less than one day: hr. min.

9. Birthplace: Balto, Md. (Town, county, and state)

10. Usual Occupation: Machinist

11. Industry or business:

FATHER
12. Name: Paul Sauers
13. Birthplace: Balto, Md.

MOTHER
14. Maiden Name: Jennie Pfeiffer
15. Birthplace: Balto, Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/24/45 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 127 St. Paul St.

19 (a) APR 22 1948 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 1948, at 7:35PM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 20 1948 to Apr. 20 1948 and that I last saw him alive on Apr. 20 1948.

Immediate cause of death: Hypertensive cardiovascular disease with congestive failure — Duration: At least 3 mos

Due to:

Due to:

Other Conditions: Arteriolar naphrosclerosis with uremia — Duration: At least 3 mos.
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed: 4/21/48

937

VS 150

C62193

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 75B

Registered No. C62193

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14da
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4810 Greenhaw Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lawrence L Alexander

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-01-8583

4. Sex: Male
5. Color or race: White
6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife Amelia E. Alexander

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22nd 1896

8. AGE: Years 51 | Months 10 | Days 28 | If less than one day: hr. min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Geo. J. Alexander
13. Birthplace W. Va.

MOTHER
14. Maiden Name Martha Archer
15. Birthplace W. Va.

16 (a) Informant Amelia E. Alexander
(b) Address 4810 Greenhaw Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/24/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. Md.
Location

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.

19 (a) APR 22 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-20 1948, at 1:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-11 1948, to 4-20 1948. And that I last saw h[illegible] alive on 4-20 1948

Immediate cause of death Peritonitis — Duration

Due to operation for splenectomy

Due to Congenital Splenomegaly

Other Conditions Pulmonary Atelectasis

(Include pregnancy within 3 months of death)

Date of operation 4-11-48

Major findings of operation: Splenomegaly

of autopsy: [illegible] atelectasis [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. H. Hallowell M. D.
Address Univ. Hosp. Date signed 4-20-48

VS 150

X

G62491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93C

Registered No. G62491

AB-117433

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 15-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29days
(e) Length of stay in Baltimore (yrs., mos., or days) 17yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 Presstman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lonnie Sisco

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Separated

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept- 1- 1899

8. AGE: Years	Months	Days	If less than one day
48	7	11	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Wesley Sisco (D

13. Birthplace Md.

MOTHER
14. Maiden Name Artie Boyer

15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/48 (month) (day) (year)

(c) Cemetery or crematory Sharptown Cem.
Location Rock Hall, Maryland

18 (a) Funeral director Asbury Henry
(b) Address Chestertown, Maryland

19 (a) APR 20 1948 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12- 1948, at 2.50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-13- 1948, to 4-12- 1948, and that I last saw him alive on 4-12- 1948.

Immediate cause of death Uremia ?

Due to H A V D (Hypertensive C-V disease)

Due to

Other Conditions Rheumatic Heart disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Not done

Duration
6 mos
6-7 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William M. Straight M. D.
Address BCH Date signed 4/12/48

VS 150

X

C62495 DOA

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. C62495

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1415 N. Baltimore St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Bledsoe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased: mo., day, yr.

8. AGE: Years | Months | Days | If less than one day: hr. min

1

9. Birthplace (Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) APR 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

VS 193

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1948 at 11:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from [illegible] to 4-13 1948 and that I last saw h[illegible] alive on [illegible] 19

Immediate cause of death Prematurity

Duration

Due to ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Martha Taylor Schoppin M.D.

Address

Date signed 4-15-48

X

G62496 VP-06852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160c

Registered No. G62496

Hospital Disposit

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl of Helen Causion VP-06852

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. 4/1/48

8. AGE: Years | Months | Days | If less than one day: hr. 1 Hr. min. newborn

9. Birthplace J Hop (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Helen ?
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Loret Cem

18 (a) Funeral director
(b) Address

19 (a) APR 22 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-1 1948, at 10:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from ..... 19.. to ..... 19.. and that I last saw h M alive on ..... 19..

Immediate cause of death: Asphyxia neonatorum

Due to: Partial Premature separation placenta

Due to:

Other Conditions: Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Above

Duration
above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Norton Long, M.D.
Address
Date signed 4/3/48

VS 193

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G62497

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 457

Registered No. G62497

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1554 Argyle Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 + 2
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1554 Argyle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Marshall
3 (b) If veteran, name war
3 (c) Social Security Account No. 213-07-6026
4. Sex Male
5. Color or race Colored
6 (a) Single, married, widowed, or divorced. M
6 (b) Name of husband or wife Rosa L. Marshall
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 8, 1893
8. AGE: Years 54 Months 5 Days 13 If less than one day hr. min.
9. Birthplace Warrington, Va (City, county, and state)
10. Usual Occupation Laborer
11. Industry or business Steel Mill
FATHER 12. Name James Marshall
13. Birthplace Warrington, Va
MOTHER 14. Maiden Name Rosa Strothers
15. Birthplace Virginia
16 (a) Informant Mrs Rosa L. Marshall
(b) Address 1554 Argyle ave
17 (a) V (Burial, cremation, or removal) (b) Date thereof 4-25-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore, Md
18 (a) Funeral director Holland Funeral Home
(b) Address 1631 Druid Hill Ave
19 (a) (b) Huntington Williams M.D. (Registrar)
APR 26 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1948, at 2 AM
21. I certify that death occurred on the date above stated, that I attended deceased from Dec. 15 1947 to April 21 1948, and that I last saw him alive on April 16 1948.

	Duration
Immediate cause of death Not known	
Due to Carcinoma of mandible	6 mos.
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Joseph D. B. King M. D.
Address 409 Hawthorn Rd Date signed Apr. 21, 1948

VS 150

Baltimore 10 X

G62498 ✓ G62498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. _____

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 LIGHT ST.
(c) Hospital or institution: SOUTH BALTO GEN HOSPITAL 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 da
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County _____
(c) City or town BALTIMORE 23 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1258 JAMES ST. (If rural give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3 (a) FULL NAME MARY ELIZABETH BAKER

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife John H. Baker
6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Oct 23, 1872

8. AGE: Years	Months	Days	If less than one day
75	5	28	hr. _____ min.

9. Birthplace Harpers Ferry W. Va (Town, county, and state)
10. Usual Occupation Nurse Wife
11. Industry or business

FATHER
12. Name Albert Roper
13. Birthplace W. Va.

MOTHER
14. Maiden Name Catherine Hedges
15. Birthplace W. Va

16 (a) Informant Dorothy V. Baker
(b) Address 1258 James St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof APR. 23 1948 (month) (day) (year)
(c) Cemetery or crematory London Park
Location City

18 (a) Funeral director Mrs. Mae. John H. Tenbrunsel
(b) Address 5311 Edmondson Ave

19 (a) APR 26 (Date rec'd by registrar) (b) _____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/20 1948 at 10:27 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/29 1948 to 4/20 1948 and that I last saw HER alive on 4/20 1948.

Immediate cause of death CARDIO RESPIRATORY FAILURE — Duration _____
Due to PULMONARY EMBOLISM — Duration _____
Due to FRACTURE of RIGHT HIP — Duration _____
Other Conditions ARTERIO SCLEROTIC HEART DISEASE. — Duration _____
(Include pregnancy within 3 months of death)
Date of operation _____
Major findings of operations _____
of autopsy: _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 21/2
(a) Accident, suicide, or homicide ACCIDENT
(b) Date of occurrence 3/29/48 at 11 A M
(c) Where did injury occur? 1258 JAMES ST. BALTO 23 (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? AT HOME (Specify type of place) While at work?
(e) Means of injury TRIPPED ON RUG

23. Signature William B. Cooper J. M. D.
Address SOUTH BALTO GEN HOS Date signed 4/20/48

VS 150

C62499

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

C62499
Registered No.

304

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green St
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 545 Hobart St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** George Green

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-20-1538

4. Sex Male | 5. Color or race Colored | 6 (a) ~~Single~~, married, ~~widowed or divorced~~

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr 12/ 1858

8. **AGE:** Years 66 | Months | Days | If less than one day hr min

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Jesse Green
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Mary J.
15. Birthplace Md

16 (a) Informant Alfred Green
(b) Address 2415 Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 24/48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Wm Bootes
(b) Address 1463 N. Carey St

19 (a) 4/23 1948 (Date rec'd by registrar) Huntington (Registrar)

MEDICAL CERTIFICATION

20. **DATE OF DEATH** 4/20 1948 at 2:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/13 1948 to 4/20 1948 and that I last saw him alive on 4/19 1948

Immediate cause of death	Duration
Subarachnoid hemorrhage	
Due to Aneurysm left anterior cerebral artery	
Due to	
Other Conditions Hypertension C.N.S. Syphilis (Include pregnancy within three months of death)	

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. **Signature** John Doerger M. D.
Address Univ. Hosp. Date signed 4/24/48

VS 153

C62500 JL - 118226

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

APR 27 1948 Registered No. 1314

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 734 Waescher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Ingram

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Div.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 18, 1874

8. AGE: Years	Months	Days	If less than one day: hr.	min.
73	6	29		

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Need ?
13. Birthplace N. C.

MOTHER
14. Maiden Name Ludie Fulton
15. Birthplace N. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 4/23/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore, Md.

18 (a) Funeral director Chas. R. Law
(b) Address 802 Madison Ave

19 (a) (Date rec'd by registrar) (b) Huntington, (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17, 1948, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19, 1948 to April 17, 1948 and that I last saw h im alive on April 17, 1948.

Immediate cause of death: Uremia — Duration: 1 mo.

Due to Arteriolar Nephrosclerosis

Due to Hypertensive Cardiovascular Disease

Other Conditions Cardiac Hypertrophy & Failure; Bronchopneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work?)
(e) Means of injury

23. Signature W. H. Armstrong, Jr. M.D. M. D.
Address Balto City Hosp Date signed 4-20-48

X

TY HEALTH DEPARTMENT ✓ 662501
Registered No.

CATE OF DEATH 46

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Lasary Hospital
(d) Length of stay in hospital or inst.: yrs., mos., or days 22 days
(e) Length of stay in Baltimore: yrs., mos., or days 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RFD, and give town)
(d) Street No. 1304 Linwood Ave (If rural give location)
(e) Citizen of foreign country? Yes or No?
If yes, name country

3 (a) FULL NAME Minnie Paul
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced married
6 (b) Name of husband or wife Samuel Paul
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Russia May 27, 1879 (If born outside the U.S. give state or country)

8. AGE: Years 46 | Months 47 | Days 10 | If less than one day: hr. min.

9. Birthplace Russia (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jacob Bloom
13. Birthplace Russia

MOTHER
14. Maiden Name Ethel Rosen
15. Birthplace Russia

16. (a) Informant Husband
(b) Address

17. (a) Burial (Burial, cremation, or removal)
(b) Date of next 4-22-48
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave
18. (a) Funeral director Jack Kevorkian
(b) Address 210 Eastern Place Huntington (White or Negro)

19. (a) April 19 1948 (Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1948 at 5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 30, 1947 to April 21 1948; and that I last saw h[illegible] alive on April 21 1948

Immediate cause of death (a) Uremia, Carcinoma Failure — Duration

Due to Carcinoma of Rectum

Due to Intestinal Obstruction

Other Conditions

Date of operation April 8, 1948

Major findings of operation: Ca of Rectum

PHYSICIAN
Underline the cause to which death should be charged statistically

(b) autopsy?

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur: about home, on farm, industrial place, in public place? (While at work)
(e) Means of injury
23. Signature J. A. Farina
Address Surg Corp Date signed 9/[illegible]/48

X

Registrar

VS 181

...ey is especially important. Physicians: please write the causes of death clearly and legibly.

C-2502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

C-2502 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4115 Kathland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town (If outside city or town limits, write RURAL, and give town)
(d) Street No. 4115 Kathland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME samuel Snyder

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Rosa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 55 | Months | Days | If less than one day: hrs. mins.

9. Birthplace: Russia
10. Usual Occupation: retired
11. Industry or business

FATHER
12. Name: Issac
13. Birthplace: Russia

MOTHER
14. Maiden Name: Sarah
15. Birthplace: Russia

16 (a) Informant: Rosa Snyder
(b) Address: 4115 Kathland ave

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof: 4-23-48 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Mt Carmel
Location: Lee Lewis Mc

18 (a) Funeral director: Lee Lewis Mc
(b) Address: 2100 Eutaw Place

19 (a) Filed: Apl 23 1948 (Date rec'd by registrar) Huntington / Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-21- 1948 at 7:15 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Dec. 1946 to Apl 1947 and that I last saw h.i.m. alive on Apl. 1947

Immediate cause of death: coronary thrombosis
Due to: coronary sclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

Duration:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature: Dr. Harold H. Bix M.D.
Address: 2516 Linden Ave Date signed: 4-22-48

Howard J. Mendelsohn, M.D. X

VS 15

662503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

662503 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~2000 Allendale Lane~~
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3525 W Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Minnie Silbert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): 9 6 0

8. AGE: Years 88 | Months | Days | If less than one day: hr min

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Borsch
13. Birthplace: Russia

MOTHER
14. Maiden Name: Ethel
15. Birthplace: Russia

16 (a) Informant: Jos Hussermann
(b) Address: ~~3525~~ 3525 W Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal): (b) Date thereof (month) (day) (year): 4-22-48

(c) Cemetery or crematory: Rosedale
Location: Philadelphia Rd-Hamilton Ave

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 200 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-21 1948, 8:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-16 1948 to 4-21 1948, and that I last saw her alive on 4-21 1948.

Immediate cause of death
PULMONARY EMBOLUS

Due to MANIPULATION OF FRACTURED LEFT HIP

Due to SPINAL ANESTHESIA

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4-21-48

Major findings of operation: DEATH ON OPERATING TABLE

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 7/17
(a) Accident, suicide, or homicide: ACCIDENT
(b) Date of occurrence 4-16-48 at 2 P M
(c) Where did injury occur? BALTIMORE (City or town) MD (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? LEVINDALE (Specify) While at work?
(e) Means of injury: FALL- Slipping - fell to floor

23. Signature: Joseph L Levine M. D.
Address: Sinai Hosp Date signed 4-21-48

Howard J. Mudeo, M.D. X

VS 150

G62504

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 83a G6[illegible]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 604 Brune St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 Brune St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harriett Richardson

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Manson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1893

8. AGE: Years 54 | Months 7 | Days 8 | If less than one day hr. min.

9. Birthplace Anne Arundel Co. Md. (Town, county, and state)

10. Usual Occupation Housemaid

11. Industry or business

FATHER 12. Name Edward Johnson

13. Birthplace Anne Arundel Co. Md.

MOTHER 14. Maiden Name Priscilla Grayson

15. Birthplace Anne Arundel Co. Md.

16 (a) Informant John E. Johnson

(b) Address 604 Brune St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 22, 1926 (month) (day) (year)

(c) Cemetery or crematory Laurel Cem.

Location Baltimore, Md.

18 (a) Funeral director or Thos. George H. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) [illegible] 1926 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 19 26 at 7:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/17 19 26 to 4/20 19 26.
and that I last saw h[illegible] alive on 4/20/26 19 26.

Immediate cause of death Cerebral hemorrhage — Duration 0 0 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 1[illegible] Druid Hill Ave. Date signed 4/27 M.D. 26

VS 150

C62505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

C62505 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1811 N. Monroe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 N. Monroe St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Helen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles [illegible]95

6 (c) If alive, give age | years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1879

8. AGE: Years 69 | Months 5 | Days 7 | If less than one day: hr. min.

9. Birthplace Sumter, S.C. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Joseph Johnson

13. Birthplace Sumter, S.C.

MOTHER 14. Maiden Name Susie Glover

15. Birthplace Sumter, S.C.

16 (a) Informant Lucas Reed

(b) Address 1941 N. Carrollton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 23, 1948 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk.

Location Baltimore, Md.

18 (a) Funeral director Wm. Carl A. Holland

(b) Address 631 Druid Hill Ave

19 (a) APR 22 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 April 1948 at 1.[illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1947 to April 1948. and that I last saw h[illegible] alive on 18 April 1948.

Immediate cause of death: Hypertension, Cerebro-renal failure — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. M. Rhoads M. D.

Address 1215 Madison Ave Date signed 19 April 48

VS 150

G62506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G62506 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 950 Homestead Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 950 Homestead Street (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN HENRY KEILBAR

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
No	213-10-0788	M	W	Married

6 (b) Name of husband or wife Mamie M. Keilbar

6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) Sept. 26,1885

8. AGE: Years	Months	Days	If less than one day
62	6	24 23	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Baltimore Transit Co.

11. Industry or business

FATHER 12. Name George Keilbar

13. Birthplace Germany

MOTHER 14. Maiden Name Anna B. Fisher

15. Birthplace Maryland

16 (a) Informant Mrs. Mamie M. Keilbar

(b) Address 950 Homestead Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/48 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery

Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.

(b) Address NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1948 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10, 1947 to Apr. 19, 1948.

and that I last saw him alive on Apr. 19, 1948.

	Duration
Immediate cause of death Pulmonary Congestion	24 hrs.
Due to Endocarditis & Myocarditis	unknown
Due to --- -	
Other Conditions Hypertension	unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Jas. W. Armstrong M.D.

Address 401 E. 25th. St. Date signed 4/21/48.

G62507 ✓ G62507

BALTIMORE CITY HEALTH DEPARTMENT Registered No. _____

CERTIFICATE OF DEATH 830

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 822 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter M. Buckner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Helen Buckner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1891

8. AGE: Years 57 | Months 2 | Days — | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Elevator Operator

11. Industry or business Post Office

FATHER
12. Name Isaac Buckner
13. Birthplace Toronto Canada

MOTHER
14. Maiden Name Lucy Boyer
15. Birthplace Chestertown Md.

16 (a) Informant Lillie Parlson
(b) Address 12 B Shields Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 23, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St.

19 (a) APR 20 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/19/48 at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/5/48 to 4/19/48 and that I last saw him alive on 4/19/48

Immediate cause of death Cerebral Thrombosis — Duration

Due to

Due to Cerebral Hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. W. Wellons M. D.
Address 1113 Hadeon Ave. Date signed 4/21/48

VS 150

G62508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G62508 ✓ Registered No. 830

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1280 RIVERSIDE AVE
(c) Hospital or institution

(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore yrs. mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1280 RIVERSIDE AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN. A. ELSNER

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-01-2118

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ELLIE ELSNER
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) MARCH 15 1877

8. AGE: Years	Months	Days	If less than one day: hr	min
71	1	5		

9. Birthplace BALTIMORE MD (Town, county, and state)
10. Usual Occupation MACHINEST
11. Industry or business ARUNDEL COPP

FATHER
12. Name JOSEPH. F ELSNER
13. Birthplace GERMANY

MOTHER
14. Maiden Name LOUISA. GEHRING
15. Birthplace GERMANY

16 (a) Informant ELLIE. ELSNER
(b) Address 1280 RIVERSIDE AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-23-48 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location A. A. Co.

18 (a) Funeral director Bernard G. Hunter
(b) Address 121 E West St

19 (a) (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 20 1948, at 12:55 P M

21. I certify that death occurred on the date above stated, that I attended deceased from March 5 1947 to April 20 1948, and that I last saw him alive on April 20 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 day

Due to: Hypertension Arterial — 1 yr

Due to:

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: - None

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(e) Means of injury

23. Signature [illegible] M.D.
Address 1279 Fulton St Date signed 4-20-48

X

662509

BALTIMORE CITY HEALTH DEPARTMENT X ✓ 662509

CERTIFICATE OF DEATH

Registered No. 50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yr-4da
(e) Length of stay in Baltimore (yrs., mos., or days) 2yr 9m 14da

2. USUAL RESIDENCE OF DECEASED:
(a) State Georgia (b) County
(c) City or town Montezoma (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Leah E Easterlin (Leah McKinzie Easterlin)

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 7 [illegible]

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: J. V. Easterlin Jr.
6 (c) If alive, give age: 58 years

7. Birth date of deceased mo., day, yr: 1-24-91

8. AGE: Years: 57 | Months: 2 | Days: 29 | If less than one day: hr. min.

9. Birthplace: Georgia (Town, county, and state)
10. Usual Occupation: housewife
11. Industry or business:

FATHER
12. Name: William MacKenzie
13. Birthplace: Ga

MOTHER
14. Maiden Name: Annie Harrison
15. Birthplace: Ga

16 (a) Informant:
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-22-48 (month) (day) (year)
(c) Cemetery or crematory: Felton
Location: Montezuma Ga.

18 (a) Funeral director: Stewart Mortuary
(b) Address: 108 W North Ave

19 (a) APR 22 1948 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1948 at 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/9 1948 to 4/22 1948 and that I last saw her alive on 4/22 1948.

Immediate cause of death: Cancer of left breast metastatic to liver — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature: S. C. Meacham

Address Date signed 4/23/48

VS (B0)

G62510

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G62510 Registered No.

8 3a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 W. Rogers Ave
(c) Hospital or institution: Methodist Home for Aged 27
(d) Length of stay in ~~hospital or inst.~~ Home (yrs., mos., or days) days
(e) Length of stay in Baltimore (yrs., mos., or days) 74 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 W. Rogers Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma C. Shinnamon

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Jones F. Shinnamon
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr 2/16/74

8. AGE: Years 74 | Months 2 | Days 6 | If less than one day: hr. min.

9. Birthplace Balto. Md
(Town, county and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John S. Derby
13. Birthplace Balto

MOTHER
14. Maiden Name Rebecca Michael
15. Birthplace Shepherdstown Va.

16. (a) Informant Mrs. Margie B Fisher
(b) Address 2211 W Rogers Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date of burial 4/25/48
(c) Cemetery or crematory David Lodge
Location Pikesville Md
18. (a) Funeral director Wm J Tickner & Sons
(b) Address Balto., Md.
19. (a) Date received APR 22 1948 Interior Williams M.D.
(Registrar) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/22 1948 at 2 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 3 1948 to April 22 1948. That I last saw him alive on April 20 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: Hours
Due to Arteriosclerosis — 20 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

22. If death was due to external causes (fill in the following):
a. Accident, suicide or homicide
b. Date of occurrence at M
c. Where did injury occur? (City or town, County, State)
d. Did injury occur while deceased was at work, industrial place or public place?
e. Manner of injury
Signature Arthur J Goodwin
Address 800 W 33rd St Date signed 4-22-48

PHYSICIAN
I subscribe the cause to which death should be charged statistically

062511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

062511

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 413 Light Street
(c) Hospital or institution South Baltimore General Hospital
(d) Length of stay in hospital or instn. (yrs., mos., or days) if dead on arrival, or brought in dead, state this fact
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give name of township)
(d) Street No. 3611 Gorsuch Oak Ave
(e) Citizen of foreign country? (Yes or No) If yes, name country

3. (a) FULL NAME John Ament

3. (b) If veteran, name war | 3. (c) Social Security Account No.
None | None

4. Sex Male | 5. Color or race White | 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Margaret L. Ament
6. (c) If married, give age 71 years

7. Birth date of deceased (mo., day, yr.) April 12, 1878

8. AGE: Years 75 | Months 0 | Days 19 | If less than one day, hours or minutes

9. Birthplace Baltimore Md.
(State, county, and town)

10. Usual Occupation Toilet Longfeiger

11. Industry or business Mfg. of Toilet Articles

12. Name of Father Matthias Ament

13. Birthplace Germany

14. Maiden Name of Mother Katie Creamer

15. Birthplace [redacted] Md.

16. (a) Informant Margaret Ament
(b) Address 3611 Gorsuch Oak Ave

17. (a) Burial (Burial, Cremation, or removal) (b) Date of burial 7/22/41
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18. (a) Funeral director Wm. R. Tucker & Son
(b) Address Govans, Md.

19. (a) 7/21/41 (Date rec'd by registrar) Registrar Williamson

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/21/41 (Month, day, year)

I hereby certify that death occurred on the date above stated, that I attended deceased from 1/1/41 to 7/21/41 and that I last saw [illegible] alive on 7/21/41

Immediate cause of death Cardiac Failure
Due to Arteriosclerotic Cardiac degeneration
Due to
Contributory Carcinoma Bladder Hydronephrosis, diabetes mellitus.
(Duration: approximate interval between onset and death)

Date of operation 3/18/41
Major findings of operation Enlarged prostate, tumor in bladder
Autopsy? Carcinoma Bladder

PHYSICIAN
Underline the cause to which death should be charged under certain circumstances.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence (Month, day, year) at (Hour)
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur above home, on farm, industrial place, in public place? (Specify which) While at work?
(e) Nature of injury

23. Signature William R. Cooper Jr.
Address South Balto. Gen. Hospital Signed 7/21/41

VS 150

CITY OF BALTIMORE

[redacted]

CERTIFICATE OF DEATH

1. PLACE OF DEATH [redacted]

Baltimore 2600 Raleigh

2 West

1. USUAL RESIDENCE (HOME) OF DECEASED

[redacted]

Baltimore

15 [illegible]

2. (a) FULL NAME

Marshall Funkhouser

2. (b) Social Security Number

[illegible]

3. SEX

M

4. COLOR OR RACE

W

5. MARRIED, NEVER MARRIED, WIDOWED, OR DIVORCED

Mary C. Funkhouser

6. DATE OF BIRTH (Month, Day, and Year)

Nov 1 1[illegible]

7a. AGE IN YEARS

76

7b. IF UNDER 1 YEAR

[illegible]

8. BIRTHPLACE (State or Foreign Country)

Baltimore Md

9. USUAL OCCUPATION

Insurance

10. KIND OF BUSINESS/INDUSTRY

Clerk Funkhouser

11. WHERE EMPLOYED

[redacted]

12. RESIDENCE

City

13. NAME OF FATHER

[illegible]

14. MAIDEN NAME OF MOTHER

Mrs Mary C. Funkhouser

15. PLACE OF BURIAL, CREMATION, OR REMOVAL

2210 N Longwood St.

16. DATE OF BURIAL, CREMATION, OR REMOVAL

Dec 12 19 [illegible]

17. UNDERTAKER

Old Bruce Bagley Chas

Harford & Md

Wash. Jackson & Sons

Balto, Md

MEDICAL CERTIFICATION

[illegible]

Carcinoma Bladder

[illegible]

Earl [illegible]

[illegible] Watson Rd.

062513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

062513

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the names of death clearly and legibly

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address 304 S Washington St
(c) Hospital or institution
(d) Length of stay in hospital or such place, none or date
(e) Length of stay in Baltimore place, none or date

2. USUAL RESIDENCE OF DECEASED
a. State Md
b. County
c. City or town Balto
d. Street No. 304 S Washington St
e. Citizen of foreign country? Yes or No
If yes, name country

3 (a). FULL NAME Mary A. Ziomek
3 (b). If veteran, regiment — Social Security Account No. 217-05-0949
4. Sex F
5. Color or race W
6 (a). Single, married, widowed, or divorced Single
6 (b). Name of husband or wife
6 (c). If widow, give age
7. Birth date of deceased (mo., day, yr.) Dec 6 1875
8. AGE Years 72 Months 4 Days 14 If less than one day, hrs. or min.
9. Birthplace Balto
10. Usual Occupation Parking Co Attendant
11. Industry or business
12. Name of father Simon Ziomek
13. Birthplace Poland
14. Maiden Name of mother Balbina Gryback
15. Birthplace Poland
16. a. Informant Martha Beck
b. Address 304 S Washington St
17. a. Burial Date thereof 4-23-48
b. Cemetery or crematory St Stanislaus
Location Dundalk Blvd
18. a. Funeral director Dippel Bros
b. Address 1800 E Lombard St
19. (a) Filed APR 22 1948 (b) Registrar Washington Nelliams M.D.

MEDICAL CERTIFICATION
20. DATE OF DEATH April 20 1948 - 11:30 A.M.
21. I certify that death occurred on the date above stated, that I attended the deceased from June 3rd 1947 to April 19th 1948, and that I last saw h[illegible] on 4/19 at 4 P.M.
Immediate cause of death
(a) Generalized sclerosis — Duration 4 yrs
Due to
(b) Carcinoma of Breast — 2
Due to
(c) Heart
Other Conditions
Operation: Date of operation; Major findings of operation
PHYSICIAN: I subscribe the cause to which death should be charged and the classification
22. If death was due to external causes, fill in the following:
a. Accident, suicide or homicide
b. Date of occurrence
c. Where did injury occur? (City or town, County, State)
d. Did injury occur while at work, in home, industrial place or public place? (Specify)
e. Manner of injury
f. Signature H J Jenkins
Address 100 N Milton Date signed 4/20/48

G62514

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. 25[illegible]

CERTIFICATE OF DEATH 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH

(a) Baltimore City, Maryland

(b) Street address 1514 - Division Ft 14

(c) Hospital or institution: Emergency room - Provident Hospital

(d) Length of stay in hospital or inst. yrs., mos., or days Dead

(e) Length of stay in Baltimore yrs. mos. or days 53 yrs

2. USUAL RESIDENCE OF DECEASED

(a) State Maryland (b) County Bal

(c) City or town Baltimore

(If outside city or town limits, write R.F.D. and give town)

(d) Street No. 1711 McCulloh

(e) Citizen of foreign country? Yes or No?

If yes, name country

3 (a) **FULL NAME** Ezekiel Leonard Lecator

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race Negro | 6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Margaret Lecator

6 (c) If alive, give age 59 years

7. Birth date of deceased: mo., day, yr. Feb. 16, 1885

8. AGE: Years 63 | Months 2 | Days 4 | If less than one day: hr. — min.

9 Birthplace Accomac Virginia (Town, county and state)

10. Usual Occupation Porter

11. Industry or business

FATHER 12. Name John Lee Lecator

FATHER 13. Birthplace Accomac, Virginia

MOTHER 14. Maiden Name

MOTHER 15. Birthplace

16 (a) Informant Mrs. Margaret Lecator Lumpkin

16 (b) Address 711 - McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/48 (month) (day) (year)

17 (c) Cemetery or crematory Mt Zion

Location Accomac Co. Va.

18 (a) Funeral director Joseph L. Bruce

18 (b) Address 1200 Mc Culloh st.

19 (a) 4/29/1948 (Date rec'd by registrar) (b) Registrar

Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1948 at 6:45 M

21. I certify that death occurred on the date above stated, that I attended deceased from April 20 1948 to April 29 1948

and that I last saw h[illegible] alive on April 29, 1948

Immediate cause of death Coronary Heart disease, acute

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

Duration Less than one hour

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at ' M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature J. Porter Hart

Address 3?K Division Date signed 4/29/48

VS 150

G62515

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G62515

171C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 1852
(b) Street address Calhoun + Fayette Sts
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3½ Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 123 S. Arlington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond A. Mills

3 (b) If veteran, name war World War II

3 (c) Social Security Account No. ✓

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Elizabeth L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 14th 1918

8. AGE: Years 29 | Months 5 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business For City

MOTHER | FATHER

12. Name Arthur M. Mills

13. Birthplace Baltimore Md.

14. Maiden Name Rena E. Dahl

15. Birthplace Baltimore Md.

16 (a) Informant Mrs Elizabeth L. Mills

(b) Address 123 So. Arlington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/48

(c) Cemetery or crematory Balto Nat'l Cem.

Location 5301 Frederick Ave

18 (a) Funeral director John J. Cowan & Son

(b) Address 901-03 Hollins St.

APR 22 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1948, at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary Edema
Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

20/4

If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 4-18-48 at 2 P.M.

(b) Where did injury occur? Frederick Ave + Pratt St.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? not

(d) Means of injury Pedestrian struck by truck

23. Signature [signature] M.D. Medical Examiner.

Date signed 4-22-48

VS 151

G62516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G62516 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1619 E Monument
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 E Monument St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James G Dales
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	colored	Married

6 (b) Name of husband or wife Viola
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 17 '71

8. AGE: Years	Months	Days	If less than one day
66	6	2	hr. min.

9. Birthplace Baltimore Md (Town, county and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Aaron Dales
13. Birthplace Balto Md

MOTHER
14. Maiden Name
15. Birthplace Baltimore Md

16 (a) Informant Viola Dales
(b) Address 1619 E Monument St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Apr 23 - 1938 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A A Co Md
18 (a) Funeral director Robert L Williams
(b) Address 1515 McCulloh St
19 (a) (Date received) (b) (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION 5T

20. DATE OF DEATH April 19 1938 at 10 PM
21. I certify that death occurred on the date above stated; that I attended deceased from Apr 12 1938 to Apr 19 1938
and that I last saw h alive on Apr 19 1938

Duration
Immediate cause of death: Cerebral hemorrhage — 8 days
Due to: Arteriosclerosis
Due to: Hypertension
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Edward Fisher M. D.
Address 1619 E Monument Date April 21 1938

C62517

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

C62517 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2435 N. Charles, St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2431 N. Charles St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha R. Harley

3 (b) If veteran, name war

3 (c) Social Security Account No. ✓

4. Sex Fe

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Geo L Harley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1867

8. AGE: Years 81 | Months 0 | Days 1 | If less than one day hr min.

9. Birthplace Carmachael, Md (Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name John Bishop
13. Birthplace Centreville, Md

MOTHER
14. Maiden Name Frances Thomas
15. Birthplace Centreville, Md

16 (a) Informant Miss Helen Harley
(b) Address 2435 N. Charles, St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Milton Ave

18 (a) Funeral director Harry E. Darby
(b) Address 1900 Eutaw Place,

19 (a) Date rec'd by registrar 4-22-1948 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1948, at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1948 to April 21 1948 and that I last saw h-e alive on April 20 1948.

Immediate cause of death	Duration
Bronchial Pneumonia	3 days
Due to Cerebral Sclerosis	6
Due to arteriosclerosis	
Other Conditions agd	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. L. Kayser M. D.
Address 1 Medical Arts Bldg

G62518

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G62518
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2712 N. Charles street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2712 N. Charles street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ANTHONY E. HERZOG

3 (b) If veteran, name war ----
3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Married

6 (b) Name of husband or wife Laura Linthicum Herzog
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) March 2, 1874

8. AGE: Years	Months	Days	If less than one day: hr.	min.
74	1	18		

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired Postman
11. Industry or business U.S. Government

FATHER
12. Name Adam Herzog
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Laura Linthicum Herzog
(b) Address 2712 N. Charles street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Eggan Son Sons
(b) Address 118 W. 9th St. Royal Ave

19 (a) (Date rec'd by Registrar) (b) Registrar

APR 22 1948 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1948 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1930 to Apr 20 1948.
and that I last saw h alive on Apr 20 1948.

Immediate cause of death Coronary Thrombosis — Duration Immediate

Due to Chr. Myocarditis with Decompensation — Duration Indefinite years

Due to Arteriosclerosis.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathaniel Wheeler M. D.
Address 1004 Eutaw Pl. Date signed Apr 22-48

X

C62519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. C62519

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 116 South Wolfe Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-71, (If outside city or town limits, write RURAL and give town)
(d) Street No. 116 South Wolfe Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosalie Skorupa Or Rozalija Skarupa

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-01-6285

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband Frank Skorupa
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr) Sept, 11-1890 ?

8. AGE: Years	Months	Days	If less than one day
57	7	10	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER / FATHER
12. Name Michael Gesior
13. Birthplace Poland
14. Maiden Name Unkonwn
15 Birthplace Unknown

16 (a) Informant Frank Skorupa
(b) Address 116 South Wolfe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-24-48 (month) (day) (year)
(c) Cemetery St. Stanisleus
Location Baltimore, Md.

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street

19 (a) 1948 (Date received by registrar) (b) Registrar

Burlington, Milwaukee, Wis.

APR 26 1948
V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21st 1948, at 5:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 16 1948 to Apr 21 1948
and that I last saw h[er] alive on Apr 21st 1948

Immediate cause of death — Duration

Coronary Occlusion — 1 day
Due to Arteri-Sclerosis — one year
Due to — one year
Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A F Rus M. D.
Address 24 E 100th Date signed Apr 22 1948

G62520

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. G62520

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4112 Edmondson Avenue
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) above address 3 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4112 Edmondson Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Isabell P Patrick

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1863

8. AGE: Years	Months	Days	If less than one day
84	4	23	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Henry Patrick
13. Birthplace

MOTHER
14. Maiden Name Charity Gertrude Patrick
15. Birthplace

16 (a) Informant Mr. Charles Patrick
(b) Address 3004 St. Paul st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Baltimore, Md.

19 (a) APR 22 1948 (date received by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1948, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 28, 1945, to April 20, 1948, and that I last saw her alive on April 20, 1948.

Immediate cause of death Cardiac failure — Duration

Due to arteriosclerotic cardio-vascular disease

Due to

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George A Kupp M. D.
Address 3030 Edmondson Ave. Date signed 4/21/48

VS 150

937

G62521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95C

G62521 Registered No.

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2434 EDMONDSON Ave
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days
(e) Length of stay in Baltimore (yrs., mos., or days 65YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2434 EDMONDSON Ave (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE S. HOLLINS

3 (b) If veteran, name war None | 3 (c) Social Security Account No. None

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. WIDOW

6 (b) Name of husband or wife CHARLES HOLLINS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 1, 1869

8. AGE: Years 79 | Months 3 | Days 20 | If less than one day hr. min

9. Birthplace LOGAN, W. Va. (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name JOHN F. WAETGE

13. Birthplace HANOVER, GERMANY

MOTHER 14. Maiden Name CATHERINE GAUER

15. Birthplace BALTO., MD.

16 (a) Informant MRS. A. L. REICHERT

(b) Address 2434 EDMONDSON Ave

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/24/48 (month) (day) (year)

(c) Cemetery or crematory WESTERN

Location BALTO; MD.

18 (a) Funeral director Wm. J. TICKNER & SONS

(b) Address BALTO; MD.

19 (a) (Date received by registrar) (b) Huntington Williams

APR 22 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/21 1948, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-28- 1941 to 4-21- 1948. and that I last saw her alive on 4-21- 1948.

Immediate cause of death: Organic heart disease — Duration

Due to

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(e) Means of injury

23. Signature Chester Riland. M. D.

Address 2532 Edmondson Ave Date signed 4-22-48

DX

G62522

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G62522 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1200 Valley St — 10 ward

(c) Hospital or institution: Home for the Aged Poor

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County City

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1200 Valley Street (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mary Dunne

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Sept 10, 1876

8. AGE: Years	Months	Days	If less than one day: Hrs.	min
71	7	11		

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER — 12. Name Walter Dunne

13. Birthplace Unknown

MOTHER — 14. Maiden Name Mary A Hare

15. Birthplace Unknown

16 (a) Informant Sister Superior Home for Aged Poor

(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road, Balto. Md.

18 (a) Funeral director George J. Ruth, Inc.

(b) Address 1735 Harford Avenue

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

APR 22 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1948, at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1948, to April 21 1948, and that I last saw h er alive on April 20 1948.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic myocarditis	5 yrs
Due to	
Other Conditions Arteriosclerosis	10 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work)

(e) Means of injury

23. Signature E Gill Hall M. D.

Address 1631 North Av Date signed 4/21/48

X

G62523 BALTIMORE CITY HEALTH DEPARTMENT G62523 Registered No.

CERTIFICATE OF DEATH 181

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland St
(c) Hospital or institution West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mo 6 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) Catonsville Manor
(d) Street No. 2828 Jonathan Englside Aves (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen L. Myers nee (Meyers)
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Philip H. Myers
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 8 1902
8. AGE: Years 45 | Months 9 | Days 13 | If less than one day hr. min.
9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER | FATHER
12. Name Benjamin F. Gary
13. Birthplace Md.
14. Maiden Name Margaret
15. Birthplace Md.

16 (a) Informant Philip H. Myers
(b) Address Harford & Englside Aves
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-23-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore Md
18 (a) Funeral director J. Howard Strong
(b) Address 3207 W. North Ave.
19 (a) Apr 22 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1948 at 10 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 21 1948 to Apr. 21 1948 and that I last saw h alive on Apr. 21 1948.

Immediate cause of death Coronary Thrombosis — Duration
Due to Pulmonary Edema
Due to Renal Failure
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? No
(e) Means of injury —
23. Signature James H. Shell M. D.
Address [illegible] Date signed 7 pm

To be signed by medical examiner. H. Rawlins M.D. H. J. Malone M.D.

VS 150

G62524

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. G62524

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Upland Road
(c) Hospital or institution: Roland Park Apts. 27-14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. Roland Park Apts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Ullysia Kahler Swindell

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: J. Rogers Swindell
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): abt. Nov-22-1865

8. AGE. Years	Months	Days	If less than one day: hr.	min.
abt. 83	3	29		

9. Birthplace: Baltimore Maryland (Town, county, and state)
10. Usual Occupation: None
11. Industry or business: None

FATHER
12. Name: Adam Kahler
13. Birthplace: Germany

MOTHER
14. Maiden Name: Margaret Osborne
15. Birthplace: Maryland

16 (a) Informant: Mrs. A. Gordon VanNess
(b) Address: Tudor Arms Apts., City #10

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Apr-23-1948 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Maryland

18 (a) Funeral director: Stewart & Mowen Company
(b) Address: 108 W. North Ave., City #1.

19 (a) (Date rec'd by registrar) APR 22 1948 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 21 1948 at 9 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 4 1947 to Apr 21 1948 and that I last saw her alive on Apr 20 1948

Immediate cause of death

(3) Chronic Myocarditis — Duration: 4 yrs more
(2) Due to Cerebral Hemiplegia (Embolic) — 1 mo
(1) Due to Coronary Thrombosis (severe) —

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, in industrial place, in public place? While at work?
(e) Means of injury

23. Signature: S. Carroll Lockard M.D.
2925 N. Charles St Date: 22 Apr 48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

S-62525 / 128

Registered No. 662525

662525

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BARRON RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Buckroe Beach (If outside city or town limits, write RURAL and give town)
(d) Street No. 360 Atlantic Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Ritter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. 6-13-47

8. AGE: Years | Months 10 | Days 5 | If less than one day: hr. min.

9. Birthplace Newport News, Va (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William C Ritter
13. Birthplace Milroy Pa

MOTHER 14. Maiden Name Catherine Lupin
15. Birthplace Lynchburg Va

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof 7/24/48 (month) (day) (year)
(c) Cemetery or crematory Newport News
Location Newport News, Va

18 (a) Funeral director Wm. J. Eckenrode
(b) Address North 26 Penna Ave

19 Filed APR 23 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-21 1948, at 1135 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-16 1948, to 4-21 1948, and that I last saw him alive on 4-21 1948.

Immediate cause of death Cardiac failure — Duration

Due to Cystic Fibrosis of the Pancreas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julian Chaplak M.D.
Address Johns Hopkins Hospital Date signed 4-22-48

VS 159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. 662526

662526

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution: none 3-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1500 Thames St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country — — —

3 (a) FULL NAME Jacob Fajtowski (Wajtowski)

3 (b) If veteran, name war ?

3 (c) Social Security account No. ?

MEDICAL CERTIFICATION

20. DATE OF DEATH April (March) 21 19 48 at 9 30 P.M.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife none

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 8-29-1893

8. AGE: Years	Months	Days	If less than one day
54	6	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Stevedore

11. Industry or business —

FATHER 12. Name Michael Fajtowski
13. Birthplace Poland

MOTHER 14. Maiden Name Victoria ?
15. Birthplace Poland

16 (a) Informant Anna Kradz
(b) Address 514 S. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-23-48 (Month) (Day) (Year)
(c) Cemetery or crematory Holy Rosary
Location Germans Mill Road

18 (a) Funeral director Lilly & Zeiler Inc
(b) Address 403 S. Wolfe St.

19 (a) APR 23 1948 (Date received by registrar) (b) [illegible] Registrar

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ (Probably), suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 2/3

(a) Date of injury Found: 4-21-48 at 6:00 A.M.
(b) Where did injury occur? Found: Floating - 7th Street Dock
(c) Did injury occur at home, on farm, industrial place, in public place? Harbor While at work? no
(d) Means of injury Found drowned

23. Signature [signature] M.D. Medical Examiner.

Date signed 4-21-48

VS 151

662527

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1948

Registered No. 662527

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital 1-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) ½ hr.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. 2925 E. Baltimore Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ida Louise Nelson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Fe.

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Joseph Nelson

6 (c) If alive, give age — years

7. Birth date of deceased mo., day, yr: March 19, 1877

8. AGE: Years 71 | Months 1 | Days 3 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Wife.

11. Industry or business

FATHER
12. Name: Otto HERRMANN
13. Birthplace: GERMANY

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-26-48 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem. Location Taylor Ave

18 (a) Funeral director Selby & Zirkus Inc

(b) Address 403 S. Wolfe St.

19 APR 23 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22, 1948, at 12:03 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/22 1948 to 4/22 1948, and that I last saw her alive on 4/22 1948.

Immediate cause of death: ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE — Duration

Due to: GENERALIZED ARTERIOSCLEROSIS

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature: Henry J. Houska, M.D.

Address: St. Jos. Hosp. Date signed 4/22/48

VS 150

G62528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. G62528

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2028 Herbert st
(c) Hospital or institution: 15-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2028 Herbert st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James T. Dolan

3 (b) If veteran, name war: WW #1

3 (c) Social Security Account No. 214-22-3917

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Katie Dolan

6 (c) If alive, give age 60 years

7. Birth date of deceased mo., day, yr: Feb 6th 1884

8. AGE: Years: 64 | Months: 2 | Days: 14 | If less than one day: hr min

9. Birthplace: Cumberland Md. (Town, county, and state)

10. Usual Occupation: Part Time Worker

11. Industry or business:

FATHER
12. Name: John Dolan
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Rose Ann Murray
15. Birthplace: "

16 (a) Informant: Katie Dolan
(b) Address: 2028 Herbert st

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/24/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~: U. S. National
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul st.

1948 APR 23 1948 Registered by Registrar: Huntington Williams M.D.

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20th 1948, at 11:30 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 19 to April 20 19 48 and that I last saw him alive on April 20 19 48

Immediate cause of death: Chronic nephritis & Uremia — Duration: 1 month

Due to:

Due to:

Other Conditions: Chronic myocarditis — Duration: two yrs.

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Harry Cashman M.D.

Address 41 W Hamilton Date signed 4/22/48

G62529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 567

G62529 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Linden Ave + Madison St

(c) Hospital or institution: Maryland General Hospital E-1

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3431 Parklawn Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Wilbur C Stiner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of ~~husband~~ wife Nellie G. Stiner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 22, 1893

8. AGE: Years	Months	Days	If less than one day
54	10	29	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Asst Supervisor

11. Industry or business Dis Bureau - City of Balto

FATHER

12. Name William H Stiner

13. Birthplace Baltimore

MOTHER

14. Maiden Name Maud I Stewart

15. Birthplace ~~Reynolds~~ Iowa

16 (a) Informant Mrs. Nellie G. Stiner

(b) Address 3431 Parklawn Ave.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/24/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Moreland Park

Location Parkville Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

19 (Date received by registrar) APR 23 1948 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1948, at 6.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1948 to April 21 1948, and that I last saw him alive on April 21 1948.

Immediate cause of death Bronchopneumonia

Due to Acute Duodenal Ulcer

Due to

Other Conditions Brain Tumor Left Temporal Lobe (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature O. Jones Hunt M. D.

Address Md Gen Hosp Date signed 4/21/48

VS '50

O. Jones Hunt 107

G62530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G62530

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2518 Edmondson Ave
(c) Hospital or institution: 16-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2518 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Theodore F. Bowen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed or divorced~~: Married

6 (b) Name of ~~husband or~~ wife Ada E. Bowen

6 (c) If alive, give age years

7. Birth date of deceased mo. Aug day 10th yr 1872

8. **AGE:** Years 75 | Months 8 | Days 10 | If less than one day hr min

9. Birthplace Tyrrell Co. N. C. (Town, county and state)

10. Usual Occupation Retired

11. Industry or business Grocery

FATHER
12. Name David A. Bowen
13. Birthplace N. C.

MOTHER
14. Maiden Name Mary E. Atkinson
15. Birthplace N. C.

16 (a) Informant Ada E. Bowen
(b) Address 2518 Edmondson Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/24/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Balto. Md.
Location

18 (a) Funeral director William Cook Inc.
(b) Address 1217 E. Paul St.

19 (a) APR 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21st 1948 at 5 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to 4/21 1948 and that I last saw ~~him~~ alive on 4/21 1948.

Immediate cause of death: Coronary thrombosis — Duration: 2 days

Due to: Myocardial degeneration — Duration: 5 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Homer L. Gould M. D.
Address 2108 E. Paul St. Date signed 4/22/48

VS 153

C62531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. C62531

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General 22-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 139 Mt Hill Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MATILDA SLOAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Greenville. S.C (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Gable Sloan
13. Birthplace S.C.

MOTHER 14. Maiden Name Janie Walker
15. Birthplace S.C.

16 (a) Informant Eugene Sloan
(b) Address 139 W. Hill St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 23-48 (month) (day)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James A Hayes
(b) Address 142 W Hill St

19 (a) APR 23 1948 (Date received by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/21/48 19 . at 3:30 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (What is work?)
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 4/21/48

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. C625532

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Ave
(c) Hospital or institution: Ardleigh Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days) 16 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County York Co.
(c) City or town New Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Florence Josephine McElwain

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Robert Byer McElwain
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 9/19/1862

8. AGE: Years	Months	Days	If less than one day
85	7	4	hr. — min.

9. Birthplace York Co Pa
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Samuel John Allen
13. Birthplace Pa

MOTHER
14. Maiden Name Mary Morrison
15. Birthplace Pa.

16 (a) Informant Mrs H.G. Hake
(b) Address New Park Pa

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4-22-48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Centre Church
Location New Park Pa

18 (a) Funeral director W Howard Wolfe
(b) Address Fawn Grove Pa.

19 (c) [illegible] Hostetter for Williams Mfr
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1948 at 10:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1946 to April 1948 and that I last saw her alive on Apr 22 1948.

Immediate cause of death Myocardial Insufficiency. — Duration 3d.
Due to Cerebral Thrombosis — 5d.
Due to Senility — 3 yr
Other Conditions Cerebral Arteriosclerosis — 3 yr
(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury .....

23. Signature H.B. McElwain M. D.
Address 31-8 North Ave Date signed 4-23-48

VS 150

C62533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. C62533

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2411 Brookfield Ave
(c) Hospital or institution:
1-3-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2411 Brookfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Cohn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 73 | Months | Days | If less than one day: hrs. min.

9. Birthplace (Town, County and State): Baltimore Md

10. Usual Occupation: retired

11. Industry or business

FATHER
12. Name: Henry Cohn
13. Birthplace: Germany

MOTHER
14. Maiden Name: Fannie
15. Birthplace: Germany

16 (a) Informant: Rena Cohn
(b) Address: 2411 Brookfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4-23-48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Hebrew
Location: Blair Road

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 2100 Eutaw Place (Funeral Home)

19 [illegible] 28, Registrar (Remington for Williams, M.D.) Registered

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-20- 1948 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 22 1948 to April 23 1948 and that I last saw him alive on April 23 1948.

Immediate cause of death: Cardiac failure (acute dilatation of heart
Due to: Coronary thrombosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Duration: 1 day; 2 yrs

Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town, County, State)
Did injury occur about home, on farm, industrial place, in public place? (While at work)
(d) Means of injury

23. Signature: J. Frederick Lang, M.D.
Address: Temple Gardens Date signed: 4/25-48

X

VS 150

G62534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G62534 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3324 Caton Ave 2nd
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos. or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md
(b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give name)
(d) Street No. 3324 Caton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If so, name country

3 (a) FULL NAME Henrietta Reed

3 (b) If veteran, name war
3 (c) Social Security Account No.

4 Sex: Female
5 Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Bernard
6 (c) If alive, give age years

7 Birth date of deceased: mo., day, yr.

8. AGE: 85 years | Months | Days | If less than one day: hr. min.

9 Birthplace: Germany (Town, county and state or foreign country)

10. Usual Occupation: Housewife
11 Industry or business

FATHER
12. Name: Aaron
13 Birthplace: Germany

MOTHER
14. Maiden Name: Ethel
15 Birthplace: Germany

16 (a) Informant: Mrs Ruth Hutter
(b) Address: 3324 Caton Ave

17 (a) Funeral (Burial, cremation or removal) (b) Date thereof: 4-26-48
(c) Cemetery or crematory: Baar Israel
Location: Southern Ave

18 (a) Funeral director: Jack Lewis
(b) Address: 2100 Eastern Ave

19 Apr 22 1948 Huntington Williams M.D. (Signature of attending physician)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-22-1948 at 2:30 A M

21. I certify that death occurred on the date stated above, and that I attended deceased from 1/19 1948 to 4/22 1948 and that I last saw h alive on 4/20 1948

Immediate cause of death
(a) Coronary Thrombosis — Duration: 2 days
Due to
(b) Hypertension
Due to
(c) Arterial Sclerosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at M
(c) Where did occurrence occur? (City or town, County, State)
(d) Did injury occur while at home, on farm, industrial place, or public place? (Specify which)
(e) Means of injury
23. Signature: Earl R Cohen
Address 2145 W Belvedere Ave (Date signed) 4/26/48

PHYSICIAN
Underline the cause to which death should be charged statistically.

662535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1942

662535
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Age should be correct age is especially important. Physicians please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
b. Street address Monument
c. Hospital or institution Sinai 15
d. Length of stay in hospital or instit. yrs. mos. or days
e. Length of stay in Baltimore yrs. mos. or days

2. USUAL RESIDENCE OF DECEASED
a. State Md
b. City or town Baltimore
c. Street No. 615 Mor and Park
d. Citizen of foreign country Yes or No?
If yes, name country

3. a. FULL NAME MRS ESTHER BLANK
b. If veteran, name war
c. Social Security Account No.
4. Sex Female
5. Color or race White
6. a. Single, married, widowed or divorced Widow
b. If married, widowed or divorced, husband or wife of
c. If above, give age years
7. Birth date of deceased mo. day yr.
8. AGE Years 72 Months Days If less than one day, hrs. or min.
9. Birthplace Russia (State or foreign country)
10. Usual Occupation Housewife
11. Industry or business
FATHER 12. Name Not known
13. Birthplace Russia
MOTHER 14. Maiden Name Not known
15. Birthplace Russia
16. a. Informant Hospital records
b. Address
17. a. Burial, Cremation or Removal Burial Date buried V 20 43
b. Cemetery or crematory Co-state
Location Liberty Rd + Hamilton Rd
18. a. Funeral director Jos Levy Inc
b. Address 2100 Eutaw Place
19. Date filed by registrar Municipal Building Baltimore, Md.

MEDICAL CERTIFICATION
20. DATE OF DEATH Apr 23 1942 - 8 AM
21. I certify that death occurred on the date above stated, that I attended the deceased from V-22-1942 to V-23-1942 and that I last saw h[illegible] alive on V-23-1942
Immediate cause of death Intestinal Obstruction
Due to Cause undetermined
Due to Coronary Sclerosis + Cardiac Failure and Bronchopneumonia
Other Conditions
Duration
Date of operation
Major findings of operation
Autopsy none
22. If death was due to external causes, fill in the following:
a. Accident, suicide or homicide
b. Date of occurrence
c. Where did injury occur?
Did injury occur while at work?
d. Means of injury
e. Injury
Address Sinai Hospital Date signed V-23-1942

PHYSICIAN
Underline the cause to which death should be charged statistically

VS 150

1221

662536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (43)

662536 Registered No.

GM. 67055

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26-17
(d) Length of stay in hospital or inst. yrs. 6 mos. or days 6 Yrs.
(e) Length of stay in Baltimore yrs. mos. or days 73 Yrs.

2. USUAL RESIDENCE OF DECEASED
a State MD. b County
c City or town Baltimore (If outside city or town limits write R.F.D. and give town)
d Street No. No Home (If rural give location)
e Citizen of foreign country? Yes or No)
If yes, name country

3 (a) FULL NAME Louisa Koch

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
F	W	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased mo. day yr 1866 - 3 - 12

8. AGE: Years	Months	Days	If less than one day
82	1	10	hr min

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Raiber
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia Brooker
15. Birthplace Germany

16 (a) Informant Records Balto. City Hospitals
b Address 4940 Eastern Ave,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 24-48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave

18 (a) Funeral director Mrs Chas. H. G. Rohde
(b) Address 2327 Edmondson Ave

19 (a) APR 22 1948 (b) Received by registrar Huntington Williams, M.D.

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 22 - 1948 at 1.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 -30 -1941 to 4 -22 - 1948, and that I last saw h 97 alive on 4 - 22 - 1948

Immediate cause of death: Bronchopneumonia, secondary

Due to

Due to

Other Conditions Arteriosclerosis
& St. hemiplegia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature William H. Kuhns Jr. M. D.
Address Balto City Hosp Date signed 4-23-48

107

G62537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G62537

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1037 N. Bay St
(c) Hospital or institution: D.O.A.
7-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write the word RURAL, and give town)
(d) Street No. 1037 N. Bay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Braun

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife John P Braun
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 22 1863

8. AGE: Years	Months	Days	If less than one day
84	4	29	hr. min.

9. Birthplace Germany
(Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Mr Frederick Hoh
(b) Address 2400 Bawlers Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-24-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Jos J Henderson
(b) Address 3061 Kenta ave

19 APR 23 1948 (Date rec'd by Registrar) (Signature of Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21 1948 at 11 A.M.

21. I ~~certify that~~ I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic CV disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C P Fuhrman M.D.
Medical Examiner.
Date signed 4/21/48

VS 15t

X

G62538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G62538

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3015 Brighton St.

(c) Hospital or institution: 16-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3015 Brighton St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME George Frick

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 220-05-3498

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Alice May Frick (Former)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1863

8. AGE: Years 85 | Months 2 | Days 8 | If less than one day hr. min.

9. Birthplace Harford Co. Md. (Town, county, and state)

10. Usual Occupation Watchman - Retired

11. Industry or business J. S. Young Co.

FATHER — 12. Name

FATHER — 13. Birthplace Germany

MOTHER — 14. Maiden Name

MOTHER — 15. Birthplace Germany

16 (a) Informant Mrs. Alice M. Frick

(b) Address 3015 Brighton St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 4/23/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Co. Md.

18 (a) Funeral director Wm. J. Tekner & Son

(b) Address Balto. Md.

19 (a) APR 23 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/20 1948, at 7:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1948, to April 20 1948, and that I last saw him alive on April 13 1948.

Immediate cause of death: Cerebral edema — Duration: 2 hrs

Due to: Age — Duration:

Due to: Arterial Sclerosis — Duration: 2 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work?)

(e) Means of injury

23. Signature John M Evans M.D.

Address 612 N 40 St Date signed

VS 189

C62539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. C62539

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1324 Northview Rd.
(c) Hospital or institution: 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1324 Northview Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Milton Leonard Jr.

3 (b) If veteran, name war: No
3 (c) Social Security Account No. Yes

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: M
6 (b) Name of husband or wife: Pauline K. Leonard
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Dec 23, 1894
8. AGE: Years: 53 Months: 3 Days: 28 If less than one day: hr. min.
9. Birthplace: Md. (town, county, and state)
10. Usual Occupation: Assistant Supt
11. Industry or business: Acadia Dist. Co.

FATHER
12. Name: John T. Leonard
13. Birthplace:

MOTHER
14. Maiden Name: Mary Costello
15. Birthplace:

16 (a) Informant: Mrs. Pauline K. Leonard - wife
(b) Address: 1324 Northview Rd.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 4/24/48 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Balto. Md

18 (a) Funeral director: Wm. Fielder & Son
(b) Address: Balto. Md

19 (a) (Date received by Registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/21 19 48 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 21 April 1948, to 21 April 1948, and that I last saw him alive on 21 April 1948.

Immediate cause of death	Duration
CORONARY THROMBOSIS	
Due to ARTERIAL Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) (While at work)
(e) Means of injury:

23. Signature: H. Kennedy Wood M. D.
Address 517 Cathedral St. Date signed 22 June 1948

VS 190

G62540

(1)

AB-118176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

G62540 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1month
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Homless (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louise Brecht

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	a SEPARATED

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9- 1902

8. AGE: Years	Months	Days	If less than one day
45	5	11	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

APR 23 1948

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20- 1948, at 1.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15 1948 to 4-20- 1948. and that I last saw h er alive on 4-20- 1948.

Immediate cause of death	Duration
1 Sepsis insufficiency	1 mo
Due to Cirrhosis, Liver, Stomach's	4 years
Due to Chronic alcholism	
Other Conditions Pyelonephritis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Cirrhosis, Pyelonephritis

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature William M Straight
Address BCH Date signed 4/21/48

VS 130

X

G62541

Dr. Wright.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G62541
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 306 East 22nd Street
(c) Hospital or institution: 12-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 306 East 22nd Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARIE MURRAY WILSON ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1863

8. AGE: Years	Months	Days	If less than one day hr	min
85				

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Micheal Murray
13. Birthplace Ireland

MOTHER
14. Maiden Name Francis Wallace
15. Birthplace Ireland

16 (a) Informant Mrs. C. Deming
(b) Address 306 East 22nd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREENMOUNT AVE & 22ND

19 (a) (Registered by) (b) Huntington Williams

APR 23 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/20/48 19 , at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1943, to Apr. 20 1948 and that I last saw h e alive on Apr. 19 1948.

Immediate cause of death: Bronchopneumonia — Duration 24 hrs.

Due to: Cellulitis of scrotum — ?

Due to: Senile senile changes. — ?

Other Conditions: Many bed sores (decubiti). (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Beth M. Williams M. D.
Address 306 E 22nd St Date signed 7-23-48

X

1625421 Travis

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

Registered No. 66542

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1409 Pressteman 2b
(c) Hospital or institution: 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 Pressteman 2b
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thos. E. Valentine

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Col	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1900

8. AGE: Years	Months	Days	If less than one day
45	3		hr. min.

9. Birthplace Baltimore Md
(City, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name Alfred Valentine
13. Birthplace Md.

MOTHER
14. Maiden Name Lucinda Lindsay
15. Birthplace Md.

16 (a) Informant Ophelia Johnson
(b) Address 1409 Pressteman St

17 (a) Burial (b) Date thereof 4/26/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Ben. H. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) APR 23 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-24- 1948, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-12- 1948 to 4-24- 1948, and that I last saw h in alive on 4-20- 1948.

Immediate cause of death Chronic Valvular Heart disease — Duration 6 mos.
Due to
Due to
Other Conditions Hemiplegia — 1 yr.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George C. Page M. D.
Address 516 N. Mount St Date signed 4-25-48

VS 180

George C. Page X

62543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 062543

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 713 Park ave
(c) Hospital or institution: 1-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 713 Park ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clarendon S. T. Gould

3 (b) If veteran, name war: —
3 (c) Social Security Account No.:

4. Sex: M.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Grace H. Gurnell
6 (c) If alive, give age: 78 years
7. Birth date of deceased: mo., day, yr. Nov 10 1862
8. AGE: Years 85 | Months 5 | Days 12 | If less than one day
9. Birthplace: Oshawa Canada (town, county and state)
10. Usual Occupation: Banker Lawyer
11. Industry or Business:

FATHER
12. Name: John T. Gould
13. Birthplace: Canada ~~Employer~~

MOTHER
14. Maiden Name: Adelaide Crook
15. Birthplace: Canada

16 (a) Informant: Frank Gurnell Gould
(b) Address: 713 Park ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Apr 25 1948
(c) Cemetery or crematory: Woodlawn
Location: Woodlawn Md

18 (a) Funeral director: Henry H. Tuttle (Co.)
(b) Address: 74 Bellona Orchard St

19. Filed: APR 23 1948 (Date filed with Registrar) Register: Wellington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1948 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 18 1947 to April 22 1948. and that I last saw h[illegible] alive on Apr 17 1948

Immediate cause of death Pneumonia — Duration 5 days

Due to Broken hip

Due to Recumbency, bronchitis

Other Conditions Arteriosclerosis

(Female, pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to an external cause, fill in the following: 4/1

(a) Accident, suicide, or homicide? accident
(b) Date of occurrence Oct 6 1947
(c) Where did injury occur? 300 block East Baltimore St
(d) Did injury occur while deceased was at work? (Specify yes or no) Public (Specify home, farm, factory, office building, etc.) No
(e) Means of injury: Slipped and fell to floor
23. Signature Henry D. M-Curdy
Address 713 W Park ave Baltimore 21 Date signed May 4 1948

Howard J. Humphreys, M.D.

662544

BALTIMORE CITY HEALTH DEPARTMENT

662544
Registered No.

CERTIFICATE OF DEATH 1316

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Underline with red pencil the cause of death directly and legibly.

1. PLACE OF DEATH

(a) Baltimore City, Maryland

(b) Street address Eastern Ave.

(c) Hospital or institution Lt Wayne Hospital

(d) Length of stay in hospital or institution (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED

(a) State Md. (b) County

(c) City or town Baltimore

(d) Street No. 1125 W. Pratt St.

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) FULL NAME Ferdinand [illegible] Faber

3. (b) If veteran, name war — Social Security Account 218 04 3390

4. Sex M — 5. Color or race W — 6. (a) Single, married, widowed, or divorced Single

6. (b) Number of husband or wife

6. (c) If widow, give age

7. Birth date of deceased 12/9/1915

8. AGE Years 3 Months 4 Days 11 If less than one day, hours or minutes

9. Birthplace Baltimore Md

10. Usual Occupation Wood Worker

11. Industry or business

FATHER

12. Name August Faber

13. Birthplace Germany

MOTHER

14. Maiden Name Deceased

15. Birthplace Germany

16. (a) Informant August J. Faber

(b) Address 1125 W. Pratt St

17. (a) Burial, cremation, or removal Burial (b) Date 4/24/48

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd

18. (a) Funeral director Hagerty Funeral

(b) Address 16 Edmondson Ave

19. (a) Date received by local registrar 4/22/48 (b) Registration No.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/20/48 at 2:55 P.M.

21. I certify that I attended the deceased from 4/13/48 to 4/20/48 and that I last saw him alive on 4/20/48

Immediate cause of death

(a) Uremia

Due to (b) Carcinoma of Prostate

(c) Metastasis

Due to

Other Conditions Influenza complicated by hemorrhage

Date of operation None

Major findings of operation

If autopsy None performed

If death was due to an external cause, fill in the following:

Accident, suicide, or homicide

Date of occurrence at M

Where did injury occur? (City or town) (County) (State)

Did injury occur while at work? (Yes or No) While in or outside of industry?

Specify type of place

Manner of injury

Nature of injury

Signature Fred A. Faber

Address 1125 W. Pratt St. Date signed 4/22/48

PHYSICIAN

Underline the name to which death should be charged should there be more than one.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered 12545

12545

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 830 Frankstown Rd
(c) Hospital or institution
16-6
(d) Length of stay in hospital or home (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(d) Street No. 830 Frankstown Rd
(e) Citizen of foreign government (Yes or No)
If yes, name country

3 (a) FULL NAME Eliza M. Harris

3 (b) If veteran, name war — 3 (c) Social Security Number —

4. Sex: F | 5. Color or race: W | 6. (a) Single, married, widowed, or divorced: widow

6. (b) Name of husband or wife: late Long H
6. (c) If widow, give age years

7. Birth date of deceased (mo., day, yr.): Feb 16, 1857

8. AGE: Years: 91 | Months: 2 | Days: 4 | If less than one day: hr. min.

9. Birthplace: Germany (city, county, and state)

10. Usual Occupation: —

11. Industry or business: —

12. Name: — Law

13. Birthplace: Germany

14. Maiden Name:

15. Birthplace: Germany

16. (a) Informant: Mrs Augusta Abraham
(b) Address: 830 Frankstown Rd

17. (a) Burial (Burial, cremation, or removal) (b) Date of burial: 4/23/47 (month, day, year)
(c) Cemetery or crematory: London Park
Location: 3901 Fredericks Rd

18. (a) Funeral director: Henry H. Wolfe
(b) Address: 4101 Edmondson Ave

19. (a) 4-22-47 (b) Registrar: Christine Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 1947

20. I certify that death occurred on the date above stated, that I attended deceased from Sept. 1946 to April 19 1947, and that I last saw ... alive on April 19, 1947

Immediate cause of death: Pneumonia
contusion colorado brain
Duration: 7 days, 7 days

Due to:

Due to:

Other Conditions: —

Contributing circumstances (Within 1 months of death):

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Disabilities the cause to which death should be charged contributed to:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town, County, State)
(d) Did injury occur above home, on farm, industrial place, or public place? While at work?
(e) Manner of injury
23. Signature: Henry Deitch
Address: 1 S. Eutaw St Date signed: 4-24-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be complete as possible. If correct age is unknown, Physicians, please write the words of death clearly and legibly. Every question is important.

652546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1918A

Registered No. 652546

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette and Caldwell Sts
(c) Hospital or institution Hospital Square 70-3
(d) Length of stay in hospital or usual residence: years, months, or days 2
(e) Length of stay in Baltimore: yrs., months, days 0 6

2. USUAL RESIDENCE OF DECEASED:
a. State Maryland County Baltimore
b. City or town Baltimore (If outside city or town limits, write R.F.D. and give number)
c. Street No. 1912 Frederick Ave (If rural give location)
d. Citizen of foreign country? Not (If yes, name country)

3. (a) FULL NAME Theresa White

3. (b) If veteran, name war — 3. (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Henry P. White
6. (c) If alive, give age years

7. Birth, date of deceased (mo., day, yr.) July 18, 1870

8. AGE: Years 77 | Months 9 | Days 4 (If less than one day, hours or minutes)

9. Birthplace Baltimore Md (Town, county and state)

10. Usual Occupation Home wife

11. Industry or business At Home

MOTHER / FATHER

12. Name Aloysius Robinson

13. Birthplace Maryland

14. Maiden Name Theresa Stegerman

15. Birthplace Maryland

16. (a) Interment Henry P White
(b) Address 1912 Frederick Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date of death April 19 48

(c) Cemetery or crematory Mount Holy Redeemer
Location Baltimore Md

18. (a) Funeral director A. B. Wagner & Son
(b) Address 1800 Eastern Ave

19. (a) APR 23 1948 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1948 at 1:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from April 20 1948 to April 23 1948, and that I last saw her alive on April 23 1948

Immediate cause of death
(a) Pneumonia

Due to (b) Acute Myocarditis

Due to (c) Hypertension Cardiovascular Disease

Other Conditions

Duration

PHYSICIAN

Underline the cause to which death should be charged (certificate results)

Date of operation

Major findings of operation

d autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bobby F. Jones M. D.
Address Franklin Square Hospital Date signed 4/23/48

98 10m

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Death subject to be passed upon by the Coroner's

BC-C 5-5785

Registered No. 6182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 701 Penna Ave

(c) Hospital or institution University Hospital (300 No

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

a State Md b County

c City or town Balto (Penna Ave

d Street No. 300 Md

(If rural, give location)

e Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME [redacted] NEAL C. THOMAS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race White

6 (a) Single, married, widowed, or divorced [redacted] SINGLE

6 (b) Name of husband or wife Dead

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. SEPT. 9, 1944

8. AGE: Years 1 | Months 7 | Days 13 | If less than one day: hr. min.

9. Birthplace (Town, county, and state) Balto. Md.

10. Usual Occupation Child

11. Industry or business

FATHER

12. Name Hampton T Thomas

13. Birthplace Balto Md.

MOTHER

14. Maiden Name Ida Anderson

15. Birthplace Md

16 (a) Informant Hampton Thomas

(b) Address Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/45 (month, day, year)

(c) Cemetery ~~or crematory~~ New Cathedral

Location Balto. Md

18 (a) Funeral director Wm J. Tickner & Son

(b) Address Balto., Md

19 (a) APR 3 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/22/45 at 3 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 4/21/45 to 4/22/45, and that I last saw h[illegible] alive on 4/22/45 at 4 P.M.

Immediate cause of death (Respiratory failure

Due to Edema of lungs following

Due to region (Fractured femur

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4/21/45

Major findings of operation Fractured femur

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 21/1

(a) Accident, suicide, or homicide accident

(b) Date of occurrence 4/20/45 at 10 P M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work?

(Specify type of place)

(e) Means of injury Patient fell from a chair

23. Signature E. B. [illegible] M.D.

Address University Hosp Date signed 4/24/45

for Dr C.J. Schmidt, by Edward J. Mullen, M.D.

VS 150

G625[illegible] MA 118915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G62548 Registered No. 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospital 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2032 E. 31 ST. St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Wise

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29, 1875

8. AGE: Years	Months	Days	If less than one day: hr.	min.
72	11	[illegible]		

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Wise (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Ellis (D)
15. Birthplace Md.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 26-/48 (month) (day) (year)

(c) Cemetery or crematory Lorraine
Location Baltimore Md.

18 (a) Funeral director Maude Cook Lyfer
(b) Address 1600 W. North Ave. Baltimore, Md.

19 (a) APR 23 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1948, at 12-50 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 13 1948 to April 22 1948, and that I last saw him alive on April 22 1948.

Immediate cause of death Bronchopneumonia? Pulmonary Edema? — Duration 9 days

Due to Senile Emphysema Arteriosclerotic Heart

Due to disease

Other Conditions Fracture of Stella (Include pregnancy within 3 months of death)

Date of operation 4-16-48 (Comminuted)

Major findings of operation: Comminuted Fracture of Stella

of autopsy:

PHYSICIAN
I underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 9/6
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 4-12-48 at 3 M
(c) Where did injury occur? Baltimore Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify) While at work? No
(e) Means of injury Fall & fracture of Stella

23. Signature J. S. Barnett M. D.
Address Baltimore City Hospitals Date signed 4/23/48
for J.R. Davis by Hunter J. Mallett M.D.

To be approved by the Medical Examiner

VS 150

G62549 G62549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 479

Registered No. _____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2952 W. North Ave.,
(c) Hospital or institution: 15-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2952 W. North Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George F. Mayers, Sr.

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife: Alverta Mayers.
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 18, 1883

8. AGE: Years	Months	Days	If less than one day: hr.	min
65	2	3		

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Plasterer,
11. Industry or business: home construction

FATHER
12. Name: George M. Mayers,
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: -- White
15. Birthplace: Ireland,

16 (a) Informant: Mrs. Alverta Mayers,
(b) Address: 2952 W. North Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 4/24/48 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: C. Vernon Lemmon.
(b) Address: 4611 Park Heights Ave.,

19 (a) APR 23 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1948, at 6.40 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 48 to 4/21 1948, and that I last saw h im alive on 4/20 1948.

Immediate cause of death: Carcinoma of lung — Duration: .....
Due to: Cerebral hemorrhage
Due to: .....
Other Conditions: .....

(Include pregnancy within 3 months of death)
Date of operation: 4/17 - March/48
Major findings of operation: Carcinoma.
of autopsy: .....

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: W. E. Reade, M.D.
Address: 2314 W. North Ave. Date signed

VS 190

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G62550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G62550 / 46F Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2529 E. Chase Street
(c) Hospital or institution: 8-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2529 E. Chase Street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Conrad Raymond Schneider

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of [redacted] or wife Helen Anna (nee Boss)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 9, 1890

8. AGE: Years	Months	Days	If less than one day
57	5	12	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business Blum's Auditing Dept.

FATHER
12. Name Adam A. Schneider
13. Birthplace Germany

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Mrs. Helen Boss Schneider
(b) Address 2529 E. Chase Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd. Balto. Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 (a) [illegible] (Date received by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1948 to April 21 1948. and that I last saw h[illegible] alive on April 20 1948.

Immediate cause of death: Carcinoma of Liver — Duration: 3 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Joseph Pokorny
Address 2200 E Madison Date signed M. 4/21/48 D.

VS 150

662551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

662551 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 3, 2

(a) Baltimore City, Maryland

(b) Street address 1200 Valley St

(c) Hospital or institution: Home for the Aged Poor

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1103 E. Pratt (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Serge Brodranchook or Prosanchuk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	W.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not know

8. AGE: Years	Months	Days	If less than one day: hr.	min.
About 70				

9. Birthplace Russian (Town, county, and state)

10. Usual Occupation Poor

11. Industry or business

FATHER

12. Name Wm. Brodranchook

13. Birthplace Russian

MOTHER

14. Maiden Name Anna

15. Birthplace Russian

16 (a) Informant Little Sisters of the Poor

(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 24 1948 (month) (day) (year)

(c) Cemetery or crematory Holy Trinity Russian Location Stone & Run, Md.

18 (a) Funeral director John L. Strebliancka Jr.

(b) Address 423 S. Paca St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1948 at 10 A M

21. I certify that death occurred on the date above stated, that I attended deceased from April 3 1948 to 4/21 1948, and that I last saw him alive on April 21 1948

Immediate cause of death

Edema Lungs — Duration: 2 days

Due to Mitral Stenosis — 5 yrs

Due to

Other Conditions Uremia Poisoning — 10 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature C Gill Hall M. D.

Address 1631 E. Monument Date signed 4/21/48

VS 180

G62552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G62552 Registered No. 830

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 611 Edgewood St
(c) Hospital or institution: 16-E
(d) Length of stay in hospital or inst. (yrs., mos., or days) /
(e) Length of stay in Baltimore (yrs., mos., or days) /

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give name)
(d) Street No. 611 Edgewood St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda E. Champayne

3 (b) If veteran, name war

3 (c) Social Security Account No. none

Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Alexander

6 (c) If alive, give age: years

7. Birth date of deceased mo., day, year: December 28-1876

8. AGE: Years: 71 | Months: 3 | Days: 26 | If less than one day: hr. min.

9. Birthplace: New York
(Town, county, and state)

10. Usual Occupation

11. Industry or business: None

FATHER
12. Name: John Fortune
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Elizabeth Philpott
15. Birthplace: England

16 (a) Informant: Thomas J. Fortune
(b) Address: 3079 Belmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: April 26, 1948 (Month) (day) (year)

(c) Cemetery or crematory: New Cathedral
Location: Balto Md

18 (a) Funeral director: Raff & B. M. Walters
(b) Address: 1911 Stricker Sts

19 (a) Filed: Apr 29 1948 (b) Transcribed in Index Book 11 # 3 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1948, at 9:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 7 1948, to April 23 1948, and that I last saw him alive on April 23 19 48:

Immediate cause of death
Cardiac Arrest
Cerebral Hemorrhage
Due to Hypertension
Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
3 da.
41 a.
10 yr.
10 yr.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which) (While at work?)
(e) Means of injury

23. Signature E. W. Koons
Address 2025 St Paul St Date signed 4-29-48

VS 150

Mbg 2 662553 BALTIMORE CITY HEALTH DEPARTMENT X662553 Registered No. 45354

CERTIFICATE OF DEATH 49a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Del. (b) County
(c) City or town Kirkwood (If outside city or town limits, write RURAL and give town)
(d) Street No. Concord Pike Rd. 2, (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Jean Machie

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	married

6 (b) Name of husband or wife James
6 (c) If alive, give age 30 years

7. Birth date of deceased mo. 8 day 13 yr 18

8. AGE: Years	Months	Days	If less than one day
29		16	hr. min.

9. Birthplace Del. (Town, county, and state)
10. Usual Occupation Nurse
11. Industry or business

FATHER 12. Name Jamie Buckley
13. Birthplace Wilm.

MOTHER 14. Maiden Name Rose Cox
15. Birthplace Wilm.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 26 1948 (Month) (day) (year)
(c) Cemetery or crematory Location Wilmington Del

18 (a) Funeral director John L. Moran
(b) Address 3000 E. Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-23 1948 at 3:35 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-11 1948 to 4-23 1948 and that I last saw her alive on 4-23 1948.

Immediate cause of death metastic cancer of ovary to mediastinum - respiratory failure

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G C Meachum
Address 4/23/48 Date signed 4/23/48
Johns Hopkins Hospital

VS 150

062554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

062554

BC-48-08145

Registered No. 182a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3E
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dov
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 322 Herring Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ronnie Faulz (FULTZ)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color of race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased: mo., day, yr.) March 7, 1948

8. AGE: Years | Mos. | Days: 24 | If less than one day: hr. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name William Fultz
13. Birthplace Kentucky

MOTHER
14. Maiden Name Carolyn Markwering
15. Birthplace Baltimore Md.

16 (a) Informant: Mrs Carolyn Fultz
(b) Address 322 Herring Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/48 (month)

(c) Cemetery or crematory Mt. Olivet
Location Mt. Carmel Road

18 (a) Funeral director: Mr. Haywood Hon
(b) Address 1808 Eastern Ave Huntington Maryland

19 (a) APR 23 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23, 1948, at 10 25 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Suffocation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-23-48 at ? 3/1 A.M.
(b) Where did injury occur? 322 Herring Court
(c) Did injury occur at home, on farm, industrial place, in public place? home (While at work) no
(d) Means of injury Rubber bag over clothes

23. Signature [signature] M.D.
Medical Examiner
Date signed 4/23/48

VS 151

Dr. Graziano
2802 Harford Road

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. C62555

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2003 E. 31st Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 East 31st Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Joseph Thaler, Sr.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Catherine L.
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr May 19, 1890

8. AGE: Years	Months	Days	If less than one day
57	11	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation President ~~Steve Business~~
11. Industry or business Geo. J. Thaler, Inc. Owner

FATHER
12. Name George J. Thaler
13. Birthplace Md.

MOTHER
14. Maiden Name Mary L. Hartell
15. Birthplace Md.

16 (a) Informant Mrs. Catherine L. Thaler
(b) Address 2003 East 31st Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-26-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer, Baltimore, Md.
Location

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, #14

19 (a) APR 23 1948 (Date received by registrar) Emmanuel Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21st, 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1947 to April 1948 and that I last saw h[im] alive on April 19, 1948

Immediate cause of death: Coronary Thrombosis — Duration: 3 days
Due to Arteriosclerosis
Due to
Other Conditions Cerebral hemorrhage May 1947
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. J. Graziano M.D.
Address 2802 Harford Rd Date signed 4/24/48 M.D.

VS 193

Dr. E.J.Alessi

G62556

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a

Registered No. G62556

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5501 Sefton Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5501 Sefton Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Frank Joseph Buettner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Josephine C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1897

8. AGE: Years	Months	Days	If less than one day
50	8	12	hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Conrad Buettner
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Kirschner
15. Birthplace Germany

16 (a) Informant Mrs. Josephine C. Buettner
(b) Address 5501 Sefton Avenue #14

17 (a) Burial (b) Date thereof 4-26-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) 4-26-1948 (b) Huntington Pellegrini
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22nd 1948, at 3.05 A M

21. I certify that death occurred on the date above stated, that I attended deceased from May 30 1947 to April 22 1948 and that I last saw h[illegible] alive on April 22 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 days

Due to: Hypertension Arteriosclerosis

Due to: cardiovascular Renal Disease — 2 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address 621 Harford Rd Date signed 4/23/48

VS 1-50

Dr. T. J. Brennan

G62557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G62557

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3010 White Avenue

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3010 White Avenue (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth R. Warns

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Francis H. Warns

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 11, 1854

8. AGE: Years	Months	Days	If less than one day
93	8	10	hr. min

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER

12. Name Samuel Davidson

13. Birthplace Md.

MOTHER

14. Maiden Name Mary Jane

15. Birthplace Md.

16 (a) Informant Mrs. Elizabeth Stuckrath

(b) Address 3010 White Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-24-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Harford Road, #14

19 (a) Apr 23 1948 (Date rec'd by registrar) Huntington Williamsburg

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21st 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1945 to 19 , and that I last saw h alive on Apr 17 1948.

Immediate cause of death Generalized Arteriosclerosis Cardiac Failure

Due to

Due to Old age

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Norman J. Brennan

Address 5305 Harford Rd Date signed 4-23-48 M.D.

VS 193

X

BALTIMORE CITY HEALTH DEPARTMENT X/99 Registered No. G62558

CERTIFICATE OF DEATH

G62558

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Waynesboro (If outside city or town limits, write RURAL and give town)
(d) Street No. 27 E. Grant St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gross Beaver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	

6 (b) Name of husband or wife

6 (c) If alive; give age years

7. Birth date of deceased (mo., day, yr.) 11-17-78

8. AGE: Years	Months	Days	If less than one day
69	6	6	hr. min.

9. Birthplace (city, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name	Abraham Beaver
FATHER 13. Birthplace	Pa
MOTHER 14. Maiden Name	Julia Musselman
MOTHER 15. Birthplace	Pa

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/27/48 (month) (day) (year)

(c) Cemetery or crematory Union Cemetery
Location Fairfield, Iowa

18 (a) Funeral director Walter G. Troxell
(b) Address Waynesboro, Pa.

19 (a) Apr 23 1948 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 50-4

20. DATE OF DEATH April 23 1948, at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/20 1948, to 4/23 1948, and that I last saw him alive on 4/23 1948.

Immediate cause of death Hemorrhage

Due to Gunshot wound abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Peter F Snader M.D.
Address [illegible] Date signed 4-29-48

VS 150

X

62553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164c

Registered No. G62559

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1018 W. Cross St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Earl Dorsey Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Ruth Dorsey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 7th 1926

8. AGE: Years 22 | Months 0 | Days 16 | If less than one day: hr min

9. Birthplace: W. Va. (Town, county, and state)

10. Usual Occupation: Mechanic

11. Industry or busines: Industrial Electric Co.

FATHER
12. Name: Robt. E. Dorsey Sr.
13. Birthplace: W. Va.

MOTHER
14. Maiden Name: Viola Sharp
15. Birthplace: Va.

16 (a) Informan: Gladys Hieff
(b) Addre: 2331 Frederick Ave

17 (a) Burial (Burial, ~~cremation or removal~~) (b) Date thereof 4/26/48 (month day year)

(c) Cemetery ~~cremation~~: U. S. National
Location: Balto. Md.

18 (a) Funeral dir: Wm Cook Inc.
(b) Address: 1217 St. Paul St.

19 (a) APR 24 1948 (Date received by registrar) (b) Huntington Williams, M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1948, at 1:05 A.M.

21. I certify that I took charge of the remains described above, held an ~~Inquest~~ Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, ~~suicide~~ ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Bullet wound of Brain

Due to

Other Conditions

(Include pregnancy within three months of death)

22. If an external cause was primary ✓ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-28-48 at 12:30 P. M.
(b) Where did injury occur? 1018 W. Cross St.
(c) Did injury occur at home, on farm, industrial place, in public place? home (While at work?) no
(d) Means of injury Gunshot

23. Signature [signature] M.D. (Medical Examiner)
Date signed April 28, 1948

VS 191

662560

BALTIMORE CITY HEALTH DEPARTMENT ★ ✓ 662560

BC-48-09484 CERTIFICATE OF DEATH 159 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County [illegible]
(c) City or town Ferndale (If outside city or town limits, write RURAL and give town)
(d) Street No. 9 Old Annapolis Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Brady
3 (b) If veteran, name war (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)
8. AGE: Years | Months | Days | If less than one day: hr. min.
9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) APR 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1948 12 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 4-18 1948 to 4-18 1948 and that I last saw him alive on 4-18 1948.

Immediate cause of death PREMATURITY — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martha Taylor Schipper M.D.
Address Johns Hopkins Date signed 4-18

VS 152

X

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 9-2 DAY OF 1963 THE MICROPHOTOGRAPHS APPEARING HEREIN STARTING WITH 52201 AND ENDING WITH 52546 ARE ACCURATE AND COMPLETE REPRODUCTIONS OF THE RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics AS DELIVERED IN THE REGULAR COURSE OF BUSINESS FOR PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC COPY.

CAMERA OPERATOR: Loretta Byrne

END OF REEL